CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

P 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED D'RING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

REQUEST FOR RETENTION PERIOD

Department: Health

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Fowler, M.D. Title: Commissioner of Health 3/18/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14 Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ]	[X]	[ ]

REMARKS:

C P Force 3/19/63
Records Management Officer Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

G69101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104

G69101

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1032 N. Stockton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 N. Stockton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robert Diggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Catherine Diggs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1898

8. AGE: Years	Months	Days	If less than one day
50	-	9	hr. min.

9. Birthplace Balto. Md.
(Town, county and state)

10. Usual Occupation Bar Tender

11. Industry or business

FATHER
12. Name James Diggs
13. Birthplace Yorktown Va.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Yorkton Va.

16 (a) Informant Catherine Diggs
(b) Address 1032 Stockton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2, 1948. (month) (day) (year)

(c) Cemetery or crematory Int. Zion
Location

18 (a) Funeral director Mrs Katie R. Stelligman
(b) Address 322 N. Schroeder St.

19 (a) DEC 2 - 1948 (Date rec'd by registrar) Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1948, to Nov. 27 1948, and that I last saw h[illegible] alive on Nov. 27 1948.

Immediate cause of death Lobar Pneumonia — Duration 2 wks

Due to

Due to

Other Conditions Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Rattley M. D.

Address [illegible] W. Fayette Date signed 11 Dec 48

VS 150

Please write clearly. Physicians: please write the causes of death clearly and legibly. Undertakers: please see that correct age is especially important.

G69:102 ZEMAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G69:102

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 361 E Cross land ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Stanley Zeman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	Married

6 (b) Name of husband or wife Mildred J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1899

8. AGE: Years	Months	Days	If less than one day
49	10	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Watchman Service
11. Industry or business "

FATHER
12. Name Mr. Frank Zeman
13. Birthplace Bohemia

MOTHER
14. Maiden Name Mary Zunt
15 Birthplace Bohemia

16 (a) Informant Hospital Record
(b) Address W. M. H.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Baltimore
18 (a) Funeral director L. J. Keyck
(b) Address 5305 Harford Rd.
19 (a) (b) Huntington Williamsport
DEC 2 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1st 1948 at 12 N

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1948 to Dec 1 1948, and that I last saw him alive on Dec 1 1948.

Immediate cause of death Cirrhosis of Liver with bleeding esophageal varices — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 25 above plus hemoperitoneum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Ward M. D.

Address Union Memorial Hosp. Date signed 12-1-48

VS 150

X

G69103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G69103 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Joseph's Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 2909 Hamilton Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** SAMUEL THOMAS SINDALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife MARGARET ANN SINDALL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-14-78

8. AGE: Years	Months	Days	If less than one day
70	7	17	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business

FATHER 12. Name David Paul Sindall

13. Birthplace Md.

MOTHER 14. Maiden Name Caroline A Saccomb

15. Birthplace Md

16 (a) Informant Mrs. Margaret Sindall

(b) Address 2909 Hamilton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Md

18 (a) Funeral director L. J. Luck

(b) Address 5305 Harford Rd.

19 (a) DEC 2 - 1948 (Date rec'd by registrar) Thurlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1-48 19 , at 6.35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27, 1948 to Dec 1, 1948 and that I last saw him alive on Dec 1, 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Uremia	
Due to Nephrosclerosis	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify trade or place)

(e) Means of injury

23. Signature Frank W. Baker, Jr. M.D.

Address St. Joseph's Hosp. Date signed 12-4-48

VS 150

669:04

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 669:04

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Northgate Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Northgate Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Le Roy Rebbel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Gertrude M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1888

8. AGE: Years	Months	Days	If less than one day
60	6	12	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John L. Rebbel
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Blamberg
15. Birthplace Md.

16 (a) Informant Mrs. Gertrude M. Rebbel
(b) Address 1519 Northgate Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) DEC 2 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1948, 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to Dec. 1 1948 and that I last saw h alive on Nov. 30 1948.

Immediate cause of death: Coronary Occlusion — Duration: 0

Due to: Coronary Sclerosis — Duration: 2 years

Due to: Hypertension

Other Conditions: Cerebral Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of inj

23. Signature H. S. Mott M. D.
Address 76 Cathedral St. Date signed 12-2-48

G69105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G69105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital W.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Evesham Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles P. Henry

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-7385

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Laura L. Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1885

8. AGE: Years	Months	Days	If less than one day
63	10	22	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Davidson Chemical C

FATHER
12. Name George Henry
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Mary Rush
15. Birthplace Penna.

16 (a) Informant Laura L. Henry
(b) Address 406 Evesham Ave

17 (a) Balto. (Burial, cremation, or removal) (b) Date thereof 12-6-48 (month) (day) (year)
(c) Cemetery or crematory Balto. Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 DEC 3 - 1948 (Date rec'd by registrar) (Registrar) for William M. Hughes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2, 1948, at 8 55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28 1948, to 12/2 1948, and that I last saw h alive on 12/2 1948

Immediate cause of death — Duration

(a) Dissecting Aortic Aneurysm — 12 hrs.
Due to A.S.H.D. — ?
Due to
Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. A. Hamm
Address Md. Gen'l. Hosp. Date signed 12/3/48

VS 150

669106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. 669106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GEN. HOSP'L
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ MOS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 137 S. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH F NORES

3 (b) If veteran, name war WORLD WAR II

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MADELINE NORES
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 7, 1922

8. AGE: Years	Months	Days	If less than one day
26	8	~~28~~ 25	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Mechanics Training
11. Industry or business Kolpack & Mitchell

FATHER
12. Name Frederick Nores
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Kurczwski
15. Birthplace Balto Md.

16 (a) Informant Bessie Nores
(b) Address 137 S. Robinson St

17 (a) Burial (b) Date thereof 12-6-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 DEC 3 - 1948 (b) Thurlington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 02 DEC 1948, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 14 OCT 1948, to 02 DEC 1948, and that I last saw HIM alive on 02 DEC 1948.

Immediate cause of death CARDIO RESPIRATORY FAICURE — Duration 3 HOURS
Due to CACHEXIA — 1 MO.
Due to HODGKINS DISEASE (MALIGNANT LYMPHOMA) — 13 MOS
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: AUTOPSY: NEOPLASTIC INVOLVEMENT OF LYMPH NODES, LIVER, SPLEEN
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald L. England M. D.
Address Maryland Gen. Hosp. Date signed Dec 48

VS 150

X

69107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No. G69107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson + Fayette Sts
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 week
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 340 S. Robinson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Thelma Smigle (THELMA ELIZABETH SMIGLE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Louis Francis Smigle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9th 1912

8. AGE: Years	Months	Days	If less than one day
36	10	23	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name James Phillips
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ann Dr Martin
15. Birthplace Balto. Md.

16 (a) Informant Louis S. Smigle
(b) Address 340 S. Robinson St.

17 (a) Burial (b) Date thereof 12-6-48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Sacred Heart
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) DEC 3 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 · 2 1948, at 2-30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11·24 1948, to 12·2 1948, and that I last saw her alive on 12·2 1948.

Immediate cause of death	Duration
Generalized carcinomatosis	
Due to	
Due to	
Other Conditions Ca of Breast	1

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. O'Callaghan M. D.
Address Bon Secours Hosp Date signed 12·2·48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69:08

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G69:08 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wakeland Wakeland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed) or divorced
male	White	widowed

6 (b) Name of ~~husband or~~ wife Cora K. Wakeland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 12th 1872

8. AGE: Years	Months	Days	If less than one day
76	3	19	hr. min.

9. Birthplace Md.
(Town, county and state)
10. Usual Occupation Real Estate
11. Industry or business Winfield Ditch

FATHER
12. Name John Archer
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E. Murray
15. Birthplace Md.

16 (a) Informant George W. Fanton
(b) Address 1614 N. Calvert St.

17 (a) Burial (b) Date thereof 12-4-48
(Burial, ~~cremation, or entombment~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 DEC 3 - 1948 (Huntington Williams M.D.) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1948 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1948 to 12-1 1948 and that I last saw h alive on 12-1-48 1948

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Heart disease	
Due to Renal sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alan White M. D.
Address University Hosp. Date signed 12-1-48

VS 159

669:09

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

669:09 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 Carroll St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Carroll St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE M. BOOKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	212-07-0724

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1892

8. AGE: Years	Months	Days	If less than one day
56	9	11	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Unemployed

FATHER
12. Name William Parks
13. Birthplace Md

MOTHER
14. Maiden Name Annie Lewis
15. Birthplace Md

16 (a) Informant Mrs Hilda Jones
(b) Address 717 Carroll St.

17 (a) Burial (b) Date thereof 12/4/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 DEC 3 - 1948 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1948 19 , at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1/48 19 to Dec 1 19 48 and that I last saw h[illegible] alive on Nov 29 19 48.

Immediate cause of death
Coronary occlusion about Duration 15 min
Due to cardio-vascular disease ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter S. Dublett M. D.
Address 1220 Harrison Blvd Date signed
Dec 2/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

69110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

Registered No. 69110

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: University Hospital
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Oidick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Clothing Business

FATHER
12. Name Abraham Oidick
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Rebecca Oidick
(b) Address 1322 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 3, 1948 (month) (day) (year)
(c) Cemetery or crematory Mishkin Israel Cem
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) DEC 3 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1948 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1948 to Dec 2 1948, and that I last saw him alive on Dec. 2 1948.

Immediate cause of death Subacute Bacterial Endocarditis
with
Due to Uremia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F Benson M.D. M. D.
Address Un Hospital Date signed 12/2/48

VS 150

X

G9111

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51B

Registered No. G69111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New York or County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. Essex House (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH DALLET

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Unclosen

6 (b) Name of husband or wife Hilda Stern
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1870

8. AGE: Years	Months	Days	If less than one day
78	3	29	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Insurance
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mr Barnett
(b) Address 3604 Clarks Lane

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12-5-48 (month) (day) (year)
(c) ~~Cemetery or~~ crematory Fresh Pond
Location New York

18 (a) Funeral director John F Denny Inc
(b) Address 715 Light St

DEC 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 2 1948, at 2:53 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from DEC. 1 1948 to DEC. 2 1948, and that I last saw him alive on DEC. 2 1948.

Immediate cause of death CEREBRAL THROMBOSIS — Duration 8 hrs.

Due to

Due to CARCINOMA OF PROSTATE — 7

Other Conditions LOBAR PNEUMONIA — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Herman M. D.
Address Sinai Hospital Date signed 12-2-48

Please write plainly, with ink or indelible pencil. Physicians: please write the causes of death clearly and legibly. Be sure that the age is correct age is especially important.

VS 193

830

69112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

69112 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 hight Street
(c) Hospital or institution: South Baltimore Gerneral Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 3016 W Fayvale St. Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Slacum

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife LaVerne A. Slacum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) February 25, 1908

8. AGE: Years	Months	Days	If less than one day
40	9	8	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business Associated Transport, Inc.

FATHER
12. Name John S. Slacum
13. Birthplace Virginia

MOTHER
14. Maiden Name Grace I. Lackey
15. Birthplace Virginia

16 (a) Informant MRS. GRACE MASON
(b) Address 3016 W. FAYVALE ST

17 (a) Burial (b) Date thereof 12/4/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location BALTO

18 (a) Funeral director JOHN T. STANSBURY
(b) Address 2700 EDMONDSON AVE

DEC 3 - 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/48 19 . at 11 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1948. to ~~Nov~~ Dec 2 1948.
and that I last saw him alive on 12/2/48 19

Immediate cause of death: Pneumonia Bilat.
a Bilat empyema (Both lungs)

Duration
days
hours
(1 m)
11/22/48

Due to Following surgery consisting of Vagotomy.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 11/27/48
Major findings of operation: Gastric ulcer.

of autopsy: Caused by Both Bases, a empyema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Marion Connolly M.D.
Address Date signed 12/2

Please write plainly, with pen or pencil, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69113

BC-48-24283

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G69113 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Avenue
(c) Hospital or institution:
Sinai Hospital of Baltimore, Inc.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 26
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Fairhaven Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Majewski

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alfred Majewski
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dolores
15. Birthplace

16 (a) Informant Mrs. Brown
(b) Address 3809 Fairhaven Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 30 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1948 1948, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 11-5 1948, and that I last saw h alive on 11-5 1948

Immediate cause of death Postmaturity

Duration

Due to (

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph A. Kunst M. D.
Address Sinai Hosp. Date signed 11/12/48

X

BC-48-25968

69114 — BALTIMORE CITY HEALTH DEPARTMENT — 69114

2568 — CERTIFICATE OF DEATH — 160a — Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor
(c) Hospital or institution: W. B. & H. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 Bolton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bradley Lee Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/21/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William M. Phillips
13. Birthplace Ardmore Okla

MOTHER
14. Maiden Name Pauline Harvey
15. Birthplace Montcalm W Va

16 (a) Informant Mrs. Pauline Phillips
(b) Address 1820 Bolton St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

Johns Hopkins Medical School DEC 1 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 DEC 3 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1948 at 7 45- P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1948, to Nov 29 1948, and that I last saw him alive on Nov 29 1948.

Immediate cause of death	Duration
# Intracranial Hemorrhage	
Due to Prematurity	
Due to	
Other Conditions Atelectasis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman Levin M. D.
Address Date signed

VS 150

X

6933.5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 6693.5

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Mt. Royal Ave
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Mt. Royal Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Agnes Laubheimer

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 27 1876

8. AGE: Years 72 | Months 4 | Days 4 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name ? ? Laubheimer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Hilda Frost
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. John G. Schilpp
(b) Address 1904 First Nat. Bank Bldg City

17 (a) Burial (b) Date thereof 12/4/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director E. Stewart & Mowen Co.
(b) Address 108 W. North Avenue

19 DEC 3 - 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1948, at 5:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 7 1948 to Dec 1 1948 and that I last saw h alive on Nov. 26 1948.

Immediate cause of death	Duration
Coronary occlusion	about 15 Min.
Due to Cardio-vascular disease	about 1 yr.
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hallie Dubbitt M. D.
Address 2220 Harlem Blvd Date signed Dec 2/48

Please print plainly. Physicians: please write the causes of death clearly and legibly. Give full name of deceased. Do not use initials. If veteran, give war or conflict. If not in hospital or institution, give residence. If married, widowed or divorced, state also name of husband or wife. If death occurred in a hospital or institution, give its name instead of street and number. If non-resident, give city or town and state. If child, how long in city or town. The Coroner is required to investigate deaths from violence, suicide, casualty, suspicious circumstances, or those occurring in jails or prisons, and to certify the cause of death.

VS 150

G69116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G69116 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Beech Ave
(c) Hospital or Institution: Wyman Park Apt - (Home)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1 Beech Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Stoner Thomas

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Harvey C. Thomas
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) June 25 1873
8. AGE: Years: Abt 75 | Months: 5 | Days: 6 5 | If less than one day: hr. min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: none
11. Industry or business: none

FATHER
12. Name: Jas. Q. Stoner
13. Birthplace: Balto

MOTHER
14. Maiden Name: Elizabeth Lednum
15. Birthplace: Balto. Md

16 (a) Informant: Mrs Geo E. Case - (cousin)
(b) Address: 207 Hopkins Rd - 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3-48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Ave., Balto #1.

19 DEC 3 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1948, at 11.25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1948 to Nov 30 1948 and that I last saw h w alive on Nov 30 1948.

Immediate cause of death
Coronary Thrombosis — Duration: 11/3/48
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D Babcock M. D.
Address 4803 Park Heights Ave Date signed 12/1/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139 B

ES-124912 Registered No. 17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVENUE
(c) Hospital or institution: BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 S. Register St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Helen Popowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 (1871) 1876

8. AGE: Years	Months	Days	If less than one day
72?	6	18	hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace Austria

MOTHER
14. Maiden Name ?
15. Birthplace Austria

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVENUE

17 (a) Burial (b) Date thereof Dec 6/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Speed of Mary
Location Balto Co.

18 (a) Funeral director A J Burgunder
(b) Address 417 Eastern ave

19 (a) (b) Huntington Williams
(Date rec'd by Registrar)
DEC 8 1948

V S 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH 12-2- 1948, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1948 to 12-2- 1948 and that I last saw her alive on 12-2- 1948

Immediate cause of death Cardio-respiratory failure
Due to malnutrition
Due to
Other Conditions paralysis & enteritis
(Include pregnancy within 3 months of death)

Duration
16 hrs
days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Craft
Address Balt City Hosp Date signed 12/2/48
M. D.

69118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 69118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT EDWARD STIDMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Florence E. Stidman
nee Watts 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1880

8. AGE: Years	Months	Days	If less than one day
67	11	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Mechan. Electrical Div.
11. Industry or business Balto. City

FATHER
12. Name George B. Stidman
13. Birthplace Bristol, England

MOTHER
14. Maiden Name Katherine Riall
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. ROBERT E. STIDMAN [illegible]
(b) Address 4217 Harcourt Rd. # 14

17 (a) Burial (b) Date thereof 12/4/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 3 - 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1948 at 2:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23- 1944 to 12-1- 1948
and that I last saw him alive on 12-1- 1948.

Immediate cause of death Arterio-Sclerotic heart disease
Coronary Sclerosis
Due to gen. arterio Sclerosis
Thoracic Neoplastic
Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
2 years
6 months
2½ yrs.
8 weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. A. Michielsen M. D.
Address 2230 Eastern Ave Date signed 12/1/48

X

669119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

669119 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2532 W. Lafayette Ave.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2532 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM JAMES MESSICK

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Etta Messick
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr) Oct. 24, 1868

8. AGE: Years	Months	Days	If less than one day
80	1	7	hr. min.

9. Birthplace Tyaskin, Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name Cad Messick
13. Birthplace Tyaskin, Md.

MOTHER
14. Maiden Name Alice Collins
15. Birthplace Md.

16 (a) Informant Mr. Arthur G. Messick
(b) Address 2532 W. Lafayette Ave.

17 (a) Burial (b) Date thereof 12/4/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 3 - 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1948, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 - 1943, to December 1 - 1948, and that I last saw h[illegible] alive on November 27 1948.

Immediate cause of death	Duration
organic heart disease	unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Riland, M. D.
Address 2532 Edmondson Ave. Date signed 12-2-48

VS 150

X

G69120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G69120

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5706 Chilham Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5706 Chilham Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ETHEL JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Marion S. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1877

8. AGE: Years	Months	Days	If less than one day
71	1	18	hr. min.

9. Birthplace Somerset Co., Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. Pusey
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Marion S. Jones
(b) Address 5706 Chilham Rd.

17 (a) Burial (b) Date thereof 12/4/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1948, at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948 to Dec 1 1948 and that I last saw h[illegible] alive on June 30 1948.

Immediate cause of death	Duration
Carcinoma of Stomach	8 months
Due to Metastases in Liver	3 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Samuel M. D.
Address 4509 Liberty Hgts Date signed Dec 2

VS 150

G69121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69121

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Fairview Ave.
(If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth F. Pipitone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Pietro F. Pipitone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/28/1888

8. AGE: Years	Months	Days	If less than one day
59	11	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Salvatore Trombetta
13. Birthplace Italy

MOTHER
14. Maiden Name Not Known
15 Birthplace Italy

16 (a) Informant Mr. Frank P. Pipitone
(b) Address 3309 Fairview Ave.

17 (a) Burial (b) Date thereof 12/4/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Dec 2 - 1948 (b) Huntingtown Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1 19 48, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 19 48, to Dec 1 19 48, and that I last saw her alive on Dec 1 19 48.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 da.
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Shell M. D.
Address Mercy Hospital Date signed Dec 1, 1948

X

VS 199

PLEASE WRITE LEGIBLY. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Please answer all questions. Be sure that the information is correct and complete. Items 1 to 19 are especially important.

G69122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G69122 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before it is filed. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Orkney Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

STRELL

3 (a) FULL NAME Robert A Rodgers

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife (nee Hackaday) Margaret I. Rodgers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 3, 1875

8. AGE: Years	Months	Days	If less than one day
73	4	29	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Gas & Elec. Co.

FATHER
12. Name James C. Rodgers
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Robinson
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret I. Rodgers
(b) Address 523 Orkney Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/48 (month) (day) (year)
(c) Cemetery or crematory Govans Presby. Cem.
Location Govans, Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 19 48 at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1948 to Dec 2 1948 and that I last saw h[illegible] alive on Dec 2 1948

Immediate cause of death Cardio-respiratory arrest. Duration

Due to Hypertensive C.V.D.

Due to Generalized arteriosclerosis

Other Conditions Cerebral vascular lesions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Tickner M.D.
Address 1241 Bolt. Blvd Date signed Dec 2

Hosp X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 66923

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Sheridan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine M. GOTH

3 (b) If veteran, name war: No

3 (c) Social Security Account No. No

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Emil Goth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1886

8. AGE: Years 62 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Weber
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah Kathers
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Bertie H. Morrow
(b) Address 3310 Orlando Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 3 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2, 1948, at 10:38 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to inhalation of illuminating-gas.

Due to

Other Conditions History of mental depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 2, 1948 app. 10 A.M.
(b) Where did injury occur? 517 Sheridan Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Oven on but unlit (Head in oven)

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12/2/48

VS 151

Please write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly.

G69124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69124

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 W. Mulberry Street
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 W. Mulburry St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA VIRGINIA LINWOOD

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Ernest Linwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 6, 1879

8. AGE: Years	Months	Days	If less than one day
68 yrs.	11	25	hr. min.

9. Birthplace Crisfield, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William R. Miles
13. Birthplace Crisfield, Md.

MOTHER
14. Maiden Name Louisa Daugherty
15. Birthplace Crisfield, Md.

16 (a) Informant Miss Helen Stokes
(b) Address 92 St. Paul St. 2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/48 (month) (day) (year)
(c) Cemetery or crematory Crisfield Cemetery
Location Crisfield, Md.

18 (a) Funeral director William J. Tickner & Son
(b) Address Baltimore, Maryland

19 (a) DEC 3 - 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1/48 19 , at 9:44 PM

21. I certify that I took charge of the remains described above, held an Inspection and Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/2/48

VS 181

G69125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G69125 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3920 Cloverhill Road
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) one year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3920 Cloverhill Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Warfel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Hester Long
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 12, 1877

8. AGE: Years	Months	Days	If less than one day
71	3	19	hr. min.

9. Birthplace Cleveland, Ohio
(Town, county, and state)
10. Usual Occupation Proprietor,
11. Industry or business Laundry business

FATHER
12. Name Jacob Warfel
13. Birthplace Switzerland

MOTHER
14. Maiden Name Lena Fisher
15. Birthplace Germany

16 (a) Informant G. Harvey Porter
(b) Address 3920 Cloverhill Road

17 (a) Entombment (b) Date thereof 12/3/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~cemetery~~ Lorraine
Location Woodlawn, Md.

18 (a) Funeral director John O. Whitehall & Sons, Inc.
(b) Address 1900 Eutaw Place

19 DEC 3 - 1948 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1948, at 4.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1948. to Dec 1 1948.
and that I last saw h~~im~~ alive on Nov. 27 1948.

Immediate cause of death	Duration
Angina pectoris	Several yrs
Due to Arteriosclerosis	years
Due to Coronary thrombosis	6 years ago
Other Conditions Three attacks of lumbago, last one 10 yrs ago	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Luetscher M. D.
Address 12 E. Eager St. Date signed Dec 1/48

VS 150

69326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G69326

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before any copies are made. Answer each question fully and correctly. If any item is unknown, so state. Do not leave any blanks. Please observe that the information called for in each item is necessary to complete the record. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 S. Luzerne Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 S. Luzerne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Veronica Karpowicz (Or) Fronie Karpowicz

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-28-7867

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband [redacted] Adam Karpowicz
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr) 1894/?

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Michalski
13. Birthplace Germany

MOTHER
14. Maiden Name Michalena Sobczak
15. Birthplace Poland

16 (a) Informant Mr. Adam Karpowicz
(b) Address 702 South Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-48 (month) (day) (year)
(c) Cemetery [redacted] St. Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) DEC 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st 1948, at 4.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Feb 1948 to 1 Dec. 1948 and that I last saw her alive on 30 Nov. 1948.

Immediate cause of death	Duration
Cardiac failure	1 wk.
Due to Carcinomatosis	1 yr.
Due to Adenocarcinoma, stomach.	1 yr.
Other Conditions Cachexia Anaemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Drozd M.D.
Address 2601 Eastern Ave Date signed 2 Dec. 48

VS 150

669127 Def. 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. 669127

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME George Monroe
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-18-83

8. AGE: Years	Months	Days	If less than one day
65	6	15	hr. min.

9. Birthplace Md (Town, county and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name George Monroe
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md

18 (a) Funeral director George T. Gilmor & Co.
(b) Address 1735 Eutaw Place

DEC 3 - 1948 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 - 1948, at 6.45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29- 1948 to 12-2 1948, and that I last saw him alive on 12-2- 1948.

Immediate cause of death Carcinomatosis — Duration

Due to Carcinoma of the Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman M. Mellinkoff M.D.
Address Johns Hopkins Hosp Date signed 12-3-48

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G69128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G69128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2310 W. Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha C. Kinesmith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Frederick P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31, 1868

8. AGE: Years	Months	Days	If less than one day
80	10	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name William Bauer
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Lotz
15. Birthplace Germany

16 (a) Informant Bertha M. Atkinson
(b) Address 2310 W. Baltimore St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3601 Frederick Ave
18 (a) Funeral director Mrs. Mrs. John W. Teufel's Son
(b) Address 5311 Edmondson Ave
19 Dec 3 1948 (Date received by local registrar) (b) Huntington for Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1948, at 2 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948, to 12/2 1948, and that I last saw her alive on 12/1 1948.

Immediate cause of death Carcinoma, Stomach — Duration

Due to

Due to

Other Conditions Arteriosclerosis Senility
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Cmac Langlelan M. D.
Address 400 N. Bryan St. Date signed 12/2/48

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669129

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 669129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1544 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 - N - Schroeder St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Femal
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sam Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5, 1900

8. AGE: Years 48 | Months 10 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Florence S.C
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Red McCalton
13. Birthplace Florence S.C

MOTHER
14. Maiden Name Lovella McCallester
15. Birthplace Florence S.C

16 (a) Informant Sam Brown
(b) Address 109 - N - Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 32 N Schroeder St

19 (a) DEC 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30, 1948 at 9.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2:30 p Nov 30 1948 to 9.20 P Nov 30 1948 and that I last saw h alive on Nov 30, 1948.

Immediate cause of death Congestive Heart failure — Duration

Due to Pulmonary Infarction

Due to Pulmonary Edema

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sadie Bradley M. D.
Address 1514 - Division Date signed Dec 7, 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

111a

G69130 Thelbert

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G69130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Pitcher St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Pitcher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelbert Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henerietta Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1877

8. AGE: Years 71 | Months 2 | Days 16 | If less than one day: hr. min.

9. Birthplace Northumberland Co. Va.
(Town, county, and state)

10. Usual Occupation Hand

11. Industry or business

FATHER
12. Name Tobacco Johnson
13. Birthplace Northumberland Co. Va.

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Northumberland Co. Va.

16 (a) Informant Henerietta Johnson
(b) Address 612 Pitcher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 3, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 3 - 1948 (Date rec'd by registrar) Thurlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1 48, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6 48 to 12/1 1948.
and that I last saw him alive on 11/30 1948.

Immediate cause of death: Chr. Nephritis & Uremia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Williams M. D.
Address 1324 D St Date signed 12/3/48

Please write clearly with pen; use ink. Physicians: please write the causes of death clearly and legibly. Be sure that the information given as to name, residence, date and place of birth, and date of death is correct and complete. Information as to color or race, marital status, and occupation is especially important.

VS 150

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669131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 669131

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1636 Ceder st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1636 Ceddof St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin Woods

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-16-6546

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carrie Woods

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29. 1899

8. AGE: Years 49 | Months | Days 4 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Labor.

11. Industry or business

FATHER
12. Name Franklin M. Woods
13. Birthplace Dont. Know

MOTHER
14. Maiden Name Dont. Know
15. Birthplace " " "

16 (a) Informant Carrie Wood
(b) Address 1636 Ceder St

17 (a) Disposition Burial (b) Date thereof Dec 6/48
(Burial, cremation, or removal) (month), (day), (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highways

18 (a) Funeral director Martin J Gormley
(b) Address 102 S 11th Ave

19 (a) DEC 3 1948 Washington Williams, M.D. Registrar
(Date rec'd by Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Dec. 1948 at 2:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner
Date signed 30 Dec. 1948

G69132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G69132 Registered No.

PLEASE WRITE PLAINLY, with pen and ink. Use no abbreviations. Fill in all blanks. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5440 Belair Rd
(c) Hospital or institution:
Gardensville Conv. Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 W Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Harvey Gosnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 30, 1865

8. AGE: Years	Months	Days	If less than one day
83	5	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown Patrick
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15 Birthplace Baltimore, Md.

16 (a) Informant Wm Lawrence Gosnell
(b) Address 17 W Biddle St.

17 (a) Burial (b) Date thereof Dec 4 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Baltimore, Md

18 (a) Funeral director Wm Cook Inc
(b) Address St Paul + Preston Sts

DEC 3 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1948, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1948 to Dec 2 1948, and that I last saw her alive on Dec 1 1948.

Immediate cause of death	Duration
Myocardial insufficiency	10 yrs
Due to Myocardial failure	
Due to Hypertensive cardio vascular disease	
Due to Arteriosclerosis	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harlold M.D.
M. D.

Address 4706 Harford Road Date signed 12/2/48

X

AdCo. 5-41 2500

669133 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 669133

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 Asquith St., Ward)

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 97 yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Annie Watts

(a) Residence: No. 112 Asquith St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Watts

6. DATE OF BIRTH (month, day, year) Oct 1851

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	97	Oct.	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. General Housework

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME Charles Adams

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Harriet Adams

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Sadie Benson

(Address) 112 Asquith St

18. BURIAL, ~~CREMATION~~, OR REMOVAL

Place Mt. Auburn Date 12/3/ 1948

19. UNDERTAKER Mrs. Lottie Gross

(Address) 1402 Ashland Ave

20. FILED DEC 3 - 1948 Huntington Williams, M.D. Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov 30, 1948

22. I HEREBY CERTIFY, That I attended deceased from June 1, 1948, to Nov 30, 1948

I last saw her alive on Nov 29, 1948 death is said to have occurred on the date stated above, at 4.30 A. m.

The principal cause of death and related causes of importance were as follows:

Cardiovascular renal complications — Date of onset 6/1/48

Other contributory causes of importance: Age

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signed) John Stewart M. D.

(Address) 622 Fremont St

In Mitch.

G69134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G69134

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 S. Smallwood St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 604 S. Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Montague

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	white	married

6 (b) Name of husband or wife Barbara Bauer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1890

8. AGE: Years	Months	Days	If less than one day
58	6	-	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Manager

11. Industry or business Balto. Elevator Co.

FATHER
12. Name John J. Montague
13. Birthplace Md

MOTHER
14. Maiden Name Anna Fowler
15. Birthplace Wash D.C.

16 (a) Informant Mrs Barbara Montague
(b) Address 604 S. Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3600 Old Frederick Rd

18 (a) Funeral director Harry A. Wright
(b) Address 4101 Edmondson Ave.

19 (a) [illegible] (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948, to Dec 1 1948, and that I last saw alive on Dec 1 1948.

Immediate cause of death Carcinomatosis of Lungs — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert C. Peters

Address 251 W. Lanvale Ave Date signed 12/3/48

VS 150

G69135

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G69135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 Woodington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Woodington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Jane Denver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4 ' 69

8. AGE: Years	Months	Days	If less than one day
79	3	10	29 hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Denver
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary
15. Birthplace Ireland

16 (a) Informant Mr Wm. R. Smyth
(b) Address 709 Woodington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4 ' 49 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Harry H. Forsythe Jr
(b) Address 4101 Edmondson Ave.

19 DEC 3 - 1949 (b) Huntington Williams, Registrar
(Date Rec'd by Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1949, at 7 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1941 to 12/2 1949 and that I last saw he/l alive on 12/1 1949

	Duration
Immediate cause of death: Cerebral Hemorrhage	12/2/49
Due to: Hypertensive & Arterio-sclerotic CV Disease	8+ yrs
Due to:	
Other Conditions: Senility	8+ yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. E. Roach x
Address 3629 Edmondson Ave. Date signed 12-6-49 M.D.

VS 150

669136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 877

669136 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. ATHOL AVE
(c) Hospital or institution:
GENERAL GERMAN AGED PEOPLES HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 ATHOL AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DIETERICKA M. HOLSTE

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION 12.50

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 25, 1867

8. AGE: Years	Months	Days	If less than one day
81	4	7	hr. min.

9. Birthplace BALTO. MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ARNOLD HOLSTE
13. Birthplace GERMANY

MOTHER 14. Maiden Name BETSIE
15. Birthplace GERMANY

16 (a) Informant MR G.J. WALZ
(b) Address 225 ATHOL AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 4 '48 (month) (day) (year)

(c) Cemetery or crematory BALTIMORE
Location E. NORTH AVE

18 (a) Funeral director Harry A. Wright
(b) Address 4101 Edmondson Ave

19 (a) DEC 6 1948 (b) Huntington-Williams, Inc.

28. DATE OF DEATH Dec. 2 1948 at A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20/48 Dec. 2/48 19 ; and that I last saw her alive on Dec. 1/48 19 .

Immediate cause of death — Duration

Multiple Sclerosis — Unknown.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Wade Stewart M. D.
Dec. 2/48.
Address 933 Hanover St. Date signed

VS 150

669137 Ph Field ✓ 669137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 669137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 S. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nellie May Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	white	widow

6 (b) Name of husband or wife late Harry W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1885

8. AGE: Years	Months	Days	If less than one day
63	10	5	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Joseph Barnes
13. Birthplace Md.

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mr. Smith - Son
(b) Address 600 S. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave & Longwood St.

18 (a) Funeral director Harry H. Sutter
(b) Address 4101 Edmondson Ave.

19 (a) [illegible] (b) Interred in Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1948, to 12/1 1948, and that I last saw h[illegible] alive on 12/1 1948.

Immediate cause of death Cafronia
Glomerulo-nephritis
Uraemia — Duration 2 10 days

Due to —

Due to —

Other Conditions Diabetes Mellitus — 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel
Address 226 Hanover St. Date signed 12/3 1948

VS 150

131a

G69138

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

Registered No. G69138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 345 W. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEOLIA WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Rufus Williams
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) May 18, 1902

8. AGE: Years	Months	Days	If less than one day
46	6	12	hr. min.

9. Birthplace Aikin Co. S.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Bright
13. Birthplace S.C.

MOTHER
14. Maiden Name Laura Moore
15. Birthplace S.C.

16 (a) Informant Rufus Willams
(b) Address 345 W. Preston St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 12/5/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director ELROY O. WILSON
(b) Address

19 (a) DEC 8 - 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 19 48 at 12:45 M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary edema

Due to Acute Congestive Heart Failure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed 11/30/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3437 Ravenwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3437 Ravenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Thomas J
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1872

8. AGE: Years	Months	Days	If less than one day
76	2	18	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Sarah Somers
13. Birthplace Md

MOTHER
14. Maiden Name Georgi Reese
15. Birthplace Md

16 (a) Informant Howard F. Williams
(b) Address 3437 Ravenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4/48 (month) (day) (year)

(c) Cemetery or crematory Balto Cem
Location Balto Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St

19 (a) DEC 3 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1948, at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30-1948 to 19 and that I last saw her alive on 11-30-1948

Immediate cause of death: Cerebral Apoplexy — Duration: 6 hrs
Due to Generalized arteriosclerosis — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton C. Haug M. D.
Address 217 Belair Rd Date signed

VS 150

X 12-2-48

669140

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. 669140

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2410 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2410 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harvey C. Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No. 217-09-2986

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28-1884

8. AGE: Years	Months	Days	If less than one day
63	11	4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Helper Coppersmith
11. Industry or business Coppersmith Co.

FATHER
12. Name Clayton Jones
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15 Birthplace "

16 (a) Informant Mrs Mary Hock
(b) Address 2410 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave.

18 (a) Funeral director John E. Miller Inc
(b) Address 2436 E. Oliver St

19 (a) Dec 3 - 1948 (Date rec'd by registrar) (b) Huntington Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2- 1948 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Oct 1947 to 2 Dec 1948. and that I last saw h alive on 2 Dec 1948

Immediate cause of death: Myocardial failure — Duration: 3 weeks
Due to: Arteriosclerosis
Due to: Rheumatic heart
Other Conditions: Arterio sclerosis nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury
23. Signature Howard Feldman
Address 1513 N. Milton Ave Date signed 3 Dec 48 D.

VS 180

97

G69141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G69141

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Provident Hospital
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2421 N Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eugene Nichols

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Widower

6 (b) Name of husband or wife Jennie Nichols 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Howard Co Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Wm Nichols
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Unknown
15. Birthplace Md.

16 (a) Informant Benj. Nichols.
(b) Address 718 N. Bruce St. Balto 17 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-48 (month) (day) (year)
(c) Cemetery or crematory West Liberty
Location Alpha Md.

18 (a) Funeral director F.C. Higginbotham
(b) Address Ellicott City Md

19 (a) [redacted] Registrar (b) Huntington Williams, M.D. Assistant

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1 1948 at 6:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1948 to Dec. 1 1948 and that I last saw h in alive on Dec. 1 1948.

Immediate cause of death	Renal Failure	Duration
Due to	Nephrosclerosis	
Due to	Generalized Arteriosclerosis	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: autopsy; generalized arterial Sclerosis; Nephrosclerosis; Bronchopneumonia of autopsy: Carbuncle of Left Kidney

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. E. Brady M. D.
Address Provident Hosp. Date signed 12-3-48

X

G69142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G69142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Chestertown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 S. Front St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert L. Wheat

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of ~~husband~~ or wife: Elizabeth W. Wheat
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-17-89

8. AGE: Years	Months	Days	If less than one day
58	11	15	hr. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual Occupation: Merchant

11. Industry or business

FATHER
12. Name: Charles Wheat
13. Birthplace: Md.

MOTHER
14. Maiden Name: Kathryn Connelly
15. Birthplace: Md.

16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12-5-48 (month) (day) (year)

(c) Cemetery or ~~crematory~~: Chester
Location: Chestertown, Md.

18 (a) Funeral director: J. Hillis Wells
(b) Address: Chestertown Md

19 DEC 3-1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1948, at 4.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1948 to 12-2 1948 and that I last saw him alive on 12-2 1948.

Immediate cause of death: Respiratory failure — Duration: [illegible]

Due to: Carcinoma — Duration: [illegible]

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Edwin Seegmiller M. D.
Address Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

669143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

Registered No. 669143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-22
(e) Length of stay in Baltimore (yrs., mos., or days) 0-2-22

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. RFD #3; Box 150; Dobgate Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Boardley

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 219-14-2191

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-13-1875

8. AGE: Years 73 | Months 3 | Days 18 | If less than one day — hr. — min.

9. Birthplace Calvert County Md.
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business None

FATHER — 12. Name John W. Boardley
13. Birthplace Calvert Co. Md.

MOTHER — 14. Maiden Name Frances E. Lear
15. Birthplace Calvert Co. Md.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-1948 (month) (day) (year)
(c) Cemetery or crematory Loudens Lehogel
Location Best Gate, Maryland

18 (a) Funeral director Wm. LeRoy C. Hicks
(b) Address 43-45 Northwest Street

19 (a) (Date received) DEC 6 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1948 at 8 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1948 to Dec. 1, 1948 and that I last saw h alive on Dec. 1, 1948

Immediate cause of death: Cardio-respiratory failure — Duration 2 hrs.

Due to: Pemphigus vulgaris — 3½ mo.

Due to:

Other Conditions: Cachexia; multiple decubiti; terminal bronchopneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pemphigus; cachexia; pulm. [illegible]

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald J. Englund, M.D.
Address Md. Gen'l. Hosp. Date signed 12/2/48

VS 150

X

69144 Dr. Helfrich
5006 Roland Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G69144 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 East 30th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 East 30th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM DAVIS STINE

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Loda A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Meat Cutter
11. Industry or business

FATHER
12. Name William D. Stine
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emma Ford
15. Birthplace Baltimore

16 (a) Informant Mrs. Loda A. Stine
(b) Address 617 East 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem. City
Location WIEDEFELD AND SON

18 (a) Funeral director GREENMOUNT AVE. & 22nd ST.
(b) Address 948 BALTIMORE - 18, MARYLAND

DEC 3 - 1948 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1st, 1948 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Dec 1948
and that I last saw him alive on Dec 1 1948

Immediate cause of death Arteriosclerotic Cardio-Vascular Disease

Due to

Due to

Other Conditions Emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Helfrich M. D.
Address 5006 Roland Ave Date signed Dec 2 '48

PLEASE WRITE PLAINLY, with ink. Spell out full words. Do not abbreviate. Be sure to answer all questions. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

669145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. 669145

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Gail Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Kraszewski (402257)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 23, 1948

8. AGE: Years	Months	Days	If less than one day
			15 hr. 44 min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thaddeus Kraszewski
13. Birthplace

MOTHER
14. Maiden Name Bernice Berulowitz
15. Birthplace New York

16 (a) Informant The Johns Hopkins Hospital
(b) Address 601 North Broadway

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

DEC 3- 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH November 23 1948, at 8:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1948 to Nov. 23 1948, and that I last saw him alive on Nov. 23 1948.

Immediate cause of death	Duration
Anoxia	
Due to Atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: atelectasis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul D. Bruns M. D.

Address The Johns Hopkins H Date signed 11-24-48

VS 150

69146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 69146

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 W. Lanvale Street
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAMANNA IRELAND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? May 4 - 1896

8. AGE: Years	Months	Days	If less than one day
52 53	8	26	hr. min.

9. Birthplace Nanticoke, Maryland
(Town, county, and state)

10. Usual Occupation Employment Office

11. Industry or business " " (at home)

FATHER
12. Name William Scott Nutter
13. Birthplace Nanticoke, Md.

MOTHER
14. Maiden Name Cornelus DeShields
15. Birthplace White Haven, Md.

16 (a) Informant Burdetta Lucas
(b) Address 1619 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/48 (month) (day) (year)
(c) Cemetery or crematory Nanticoke, Md.
Location " "

18 (a) Funeral director Virginia Brooks
(b) Address 1463 North Carey Street

19 (a) DEC 4 - 1948 (Rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1948, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.

Date signed 12/1/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669147

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Randallstown (If outside city or town limits, write RURAL and give town)
(d) Street No. Old Court Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas A. Russell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Anna S. Frock Russell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1879

8. AGE: Years	Months	Days	If less than one day
69	8	0	hr. min.

9. Birthplace Randallstown, Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name William Wallace Russell
13. Birthplace Randallstown, Md.

MOTHER
14. Maiden Name Jane Cummings
15. Birthplace Maryland

16 (a) Informant Mr. Thomas Russell
(b) Address Old Court Road, Randallstown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Willis Lawrence
(b) Address 4520 Liberty Heights Ave.

19 (a) DEC 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1948, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to Dec 2 1948 and that I last saw him alive on Dec 1 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis	5 yrs
Due to Hypertension	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R Kleiman M.D.
Address 3803 Edmondson Ave Date signed 12/2/48 M. D.

G69148 Ret Room
Med. Exam Case
Released To Hosp

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G69148

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John B. Woernlein

3 (b) If veteran, name war WW I
3 (c) Social Security Account No. 212-09-1718

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Widow

6 (b) Name of husband or wife Daisy Woernlein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-95

8. AGE: Years	Months	Days	If less than one day
53	9	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Paper Box Cutter
11. Industry or business Chas Kelly P.B. Co

FATHER
12. Name Charles Woernlein
13. Birthplace ? Baltimore

MOTHER
14. Maiden Name Isabel Lemperouse
15. Birthplace ?Md

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6/48 (month) (day) (year)
(c) Cemetery or crematory WM Garrett
Location Baltimore

18 (a) Funeral director Philips Funeral Home
(b) Address 2028 Eutaw Pl

19 (a) DEC 4 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1948 at 2 15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 19 , to Dec 3 19 , and that I last saw h alive on 19 .

Immediate cause of death ? Coronary
Due to occlusion
Due to
Other Conditions

Duration

(Including conditions contributing to the death but not related to the immediate cause of death)

CERTIFICATION APPROVED BY
Wm. H. Kammer, M.D.

Date of operation
Major findings of operation:
Per M.D.
of autopsy: CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William W. Winternitz M.D.
Address Johns Hopkins Hospital Signed 12-3-48

VS 15 To be approv. by Med-Exam

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

48B

Registered No. G69149

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution: Good Samaritan Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Winchester St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	

6 (b) Name of husband or wife Kemper Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace Unknown (Town, county and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Good Samaritan Hospital
(b) Address 27 N Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Maryland

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave

19 DEC 4 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26/48 19 , at 6 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11/48 19 to 11/26/48, and that I last saw her alive on 11/24 1948.

Immediate cause of death: Cancer Uterus — Duration: unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter D Lomax M. D.
Address 401 E Lanvale St Date signed 12/6/48

Please write clearly. Physicians: please write the causes of death clearly and legibly. Also correct age is especially important.

VS 150

G69150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G69150

LCH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Shuter Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME LOTTIE FORREST

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/30/93

8. AGE: Years	Months	Days	If less than one day
55	6	4	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Jane Gaylor
13. Birthplace ? Maryland

MOTHER
14. Maiden Name ? Louise
15. Birthplace ? Maryland

16 (a) Informant B.C.H. Records Lillie Mae Bennett
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Balto Co. Md.

18 (a) Funeral director Wm. G. Judkins
(b) Address 916 Fenno Ave

19 DEC 4 - 1948 (Date rec'd by Registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3/ 1948 at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 19 48 to 12/3/48 19 and that I last saw her alive on 12/3/48 19

Immediate cause of death Cardiac failure ?

Due to Arteriosclerotic heart disease

Due to

Other Conditions Diabetes mellitus
Gangrene of foot
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: none done

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David H. Marcus M.D.
Address Balto City Hosp Date signed 12-3-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

939

669151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669151

488

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2316 Eutaw Place
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 Eutaw Place (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza N. Kirwan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles R. Kirwan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 24, 1863

8. AGE: Years	Months	Days	If less than one day
85	6	9	hr. min.

9. Birthplace Aberdeen, Harford County, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Calvin Michael
13. Birthplace Harford County, Md.

MOTHER
14. Maiden Name Ann Martha Mitchell
15. Birthplace Harford County, Md.

16 (a) Informant Mrs. Nina K. Bubert
(b) Address 4902 Wilmslow Road

17 (a) Entombment (b) Date thereof 12/4/48 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Grove
Location Aberdeen, Maryland

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1800 Eutaw Place

19 (a) DEC 4 - 1948 (Date rec'd by registrar) Harrington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1948 at 12.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Dec 2, 1948.
and that I last saw her alive on 11/30/48 19

Immediate cause of death Acute coronary disease — Duration sudden

Due to General arterial sclerosis — Duration Long

Due to Senility

Other Conditions Chr Valvular heart disease and chronic nephritis

Operation (Include pregnancy within 3 months of death)
Date of operation Uterine cancer
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Lewis Lamb M.D.
Address 1901 Eutaw Place Date signed 12/3/48 M. D.

VS 150

131a

69152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G69152

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2833 E. Federal Street

(c) Hospital or institution:

8 1 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2833 E. Federal Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis J. Bender

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Thelma Bender (nee Quaty)

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): May 30, 1908

8. AGE: Years: 40 | Months: 6 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Mill Worker

11. Industry or business

FATHER

12. Name: Charles Bender (deceased)

13 Birthplace: Baltimore, Md.

MOTHER

14. Maiden Name: Mary Hovadek

15 Birthplace: Baltimore, Md.

16 (a) Informant: Thelma Bender

(b) Address: 2833 E. Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/48 (month) (day) (year)

(c) Cemetery or ~~xxxxxx~~: Holy Redeemer

Location: 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director: Schimunek Funeral Home Inc.,

(b) Address: 2601-05-05 E. Madison Street

19 (a) Dec 4 - 1948 (b) Filed by (Registrar) Huntington Williams, MD Registrar

Dec

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1948, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Oct 1948 to 2 Dec 1948, and that I last saw h[illegible] alive on 26 Nov 1948.

Immediate cause of death: Coronary Occlusion, recurrent — Duration: 12 hours.

Due to: Recurrent

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury: Coolman

23. Signature: Howard Coolman

Address: 1515 N. Milton Ave Date signed 4 Dec 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G69153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G69153 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mont. (b) County
(c) City or town Helena
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 N. Rodney St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick R. Kasperick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-11-46

8. AGE: Years	Months	Days	If less than one day
2	10	23	hr. min.

9. Birthplace Montana
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Kasperick
13. Birthplace Minn.

MOTHER
14. Maiden Name Cath. Blesner
15. Birthplace Minn

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/4/48 (month) (day) (year)

(c) Cemetery or crematory
Location Helena, Montana.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 260[illegible]-3-5 E. Madison Street

19 (a) DEC 4 - 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1948 at 1 36 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1948 to 12/3 1948 and that I last saw him alive on 12/3 1948

Immediate cause of death anoxia — Duration

Due to Heart failure

Due to congenital malf. of heart.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes - not reported.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. A. Hanson M.D.

Address Johns Hopkins Hosp. Date signed 12/3/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

69154 LAURA BALTIMORE CITY HEALTH DEPARTMENT ✓ G69154

CERTIFICATE OF DEATH 131B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1026 Edmondson ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Sara Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-1875

8. AGE: Years 73 | Months 2 | Days - | If less than one day hr. min.

9. Birthplace Long Lick md (Town, county, and State)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name unknown
13. Birthplace " "

MOTHER 14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Florence Chase
(b) Address 1026 Edmondson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Braddish ave

19 (a) DEC 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

12-1-48 MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1 1948, at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1948 to Dec 1 1948, and that I last saw h e alive on Nov 30 1948

Immediate cause of death	Duration
Chronic Parenchymatous Nephritis	unknown
Due to (uremia)	
Due to	
Other Conditions Chronic Myocarditis (general debility)	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph K. Young M. D.
Address 1424 E Monument Date signed 12/3/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

69155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. 69155

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd + Calvert Sts.

(c) Hospital or institution: Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore B, Maryland
(If outside city or town limits, write RURAL and give town)

(d) Street No. 322 East 27th St.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche M. Kavanaugh

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Charles P. Kavanaugh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/1894

8. AGE: Years	Months	Days	If less than one day
54	9	13	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER

12. Name William Hare (D)

13. Birthplace Baltimore Md.

MOTHER

14. Maiden Name Amanda Redann (D)

15 Birthplace Baltimore Md.

16 (a) Informant Chas Kavanaugh

(b) Address 322 E. 27th St.

17 (a) Burial (b) Date thereof Dec 6, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 900 East Biddle St

19 (a) DEC 4 - 1948 (b) Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1948. to Dec 3 1948.

and that I last saw her alive on Dec. 3 1948

Immediate cause of death	Duration
Cerebral embolism	
Due to Thrombosis, L. auricle	
Due to Rheumatic heart disease	
Other Conditions Arteriosclerosis, Generalized	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Glenn F. Moore

Address Union Memorial Hosp. Date signed 12 M. 12/3/48

VS 190

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G69156 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2606 Lehman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Lehman St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Emma O. Burton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Burton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-17-1872

8. AGE: Years 76 | Months 1 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name William Wrestling
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Austin W. Burton
(b) Address 2606 Lehman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 (a) DEC 4 1948 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1st 1948, at 2:A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to 1 Dec 1948, and that I last saw h[illegible] alive on 1 Dec 1948.

Immediate cause of death	Duration
Myocarditis	3 yrs.
Due to Arterio-sclerosis	10 yrs.
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Hooper M. D.

Address 3534 Eastern Ave Date signed 3 Dec

X

G69157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G69157

Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry made on this certificate is permanent record. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 East 29th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 East 29th St
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME BETTIE SCHMIDT KRUMM

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Henry L. Krumm
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Sept 21 1863
8. AGE: Years 85 Months 2 Days 11 If less than one day — hr. — min.
9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name: Ludwig Schmidt
13. Birthplace: Germany

MOTHER
14. Maiden Name —
15. Birthplace: Germany

16 (a) Informant: Albert Krumm
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/48 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore Md

18 (a) Funeral director: J. A. Rynhart Son
(b) Address: 300 Eutaw Place

19 (a) DEC 4 - 1948 (Date rec'd by registrar) (b) Thurlington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 1948 at 6 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1948 to Dec 2 1948 and that I last saw her alive on 12-1 1948

Immediate cause of death: CEREBRAL VASCULAR ACCIDENT — Duration 11-28 6

Due to: ARTERIAL HYPER-TENSION

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature: Walter E. Hopkins M.D.
Address 1331 Hartford Rd Date signed 12-4-48

G69158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69158

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 53 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Pasa St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Bracato

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-7093

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Theresa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1884

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Fruit Dealer
11. Industry or business

FATHER
12. Name Salvatore Bracato
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Liberto
15. Birthplace Italy

16 (a) Informant Sarah Liberto
(b) Address 309 N. Greene Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road

18 (a) Funeral director Joseph Favaro Sons.
(b) Address 2916 Greenmount Ave

19 (a) DEC 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1948 at 8:04 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1948, to Dec. 3 1948, and that I last saw him alive on Dec. 3 1948.

Immediate cause of death	Duration
Shock	2 hours
Due to Dissecting Aortic Aneurysm?	?
Due to Hypertensive Arteriosclerotic heart disease	? years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred H. Dann
Address Maryland General Hospital Date signed M 12 D 3/48

VS 180

G69159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. G69159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 Barclay St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANGELO MAIOLI

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-16-4648A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Virginia Maioli
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 22, 1871

8. AGE: Years	Months	Days	If less than one day
77	3	11	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Grigorio Maioli
13. Birthplace Italy

MOTHER
14. Maiden Name Matilda --
15. Birthplace Italy

16 (a) Informant Mr. Joseph M. Villa, son-in-law
(b) Address 1809 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 4 - 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1948 to 12-3 1948, and that I last saw him alive on 12-3 1948.

Immediate cause of death	Duration
Carcinoma of Stomach	6 mo
Due to Generalized Carcinomatosis	1 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 11 Chase St Date signed 12-4-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69160

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 B

Registered No. G69160

PLEASE WRITE PLAINLY, with unfading ink. Do not use abbreviations. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5655 Lothian Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5655 Lothian Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD HARWOOD SWITZER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	705-12-5316

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lucille A. Switzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 6, 1910

8. AGE: Years	Months	Days	If less than one day
38	2	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Circuit Draftsman
11. Industry or business B. & O. R. R.

FATHER
12. Name George Franklin Switzer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma Caroline Spieker
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lucille A. Switzer
(b) Address 5655 Lothian Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.6.48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2, 1948 at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947 to Nov 28 1948, and that I last saw him alive on Nov 28 1948.

Immediate cause of death Heart failure — Duration

Due to Chronic Rheumatic H.D. with mitral & aortic stenosis &

Due to Mitral insufficiency

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter B. Buch M. D.
Address 18 E. EAGER ST. Date signed Dec 3, 48

X

G69161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson & Fayette Sts.
(c) Hospital or institution:
Bon Secours Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary B. Fletcher

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Harrison F. Fletcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1895

8. AGE: Years	Months	Days	If less than one day
53	8	24	hr. min.

9. Birthplace Hagerstown, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Magee
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emma Dickson Storey
15 Birthplace Baltimore

16 (a) Informant Mr. Harrison F. Fletcher
(b) Address 2420 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) DEC 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1948, at 4:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19/1948 to 12/4/1948, and that I last saw h er alive on 12/4/1948.

Immediate cause of death Subarachnoid hemorrhage — Duration
Due to Hypertension and
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23 Signature D. S. Mohler M. D.
Address Bon Secours Hosp. Date signed 12/4/48

D. S. Mohler X

VS 150

669162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 669162

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Raynor ave + Dukeland St.

(c) Hospital or institution: West Baltimore General Hosp 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1109 Homestead St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry S. Fonshell

3 (b) If veteran, name war: Spanish American

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mary Rebecca Fonshell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/17/66

8. AGE: Years 82 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace Newark, Ohio (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business Pipe Fitter - retired

FATHER

12. Name Jacob Fonshell

13. Birthplace --

MOTHER

14. Maiden Name Emma Boyer

15. Birthplace --

16 (a) Informant Mr. William R. Fonshell

(b) Address 1109 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem. Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) DEC 4 - 1948 (Date rec'd by registrar) (b) Certificate for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 1948, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1948, to 12/3 1948, and that I last saw him alive on 12/3 1948

Immediate cause of death: Atelectasis — Duration

Due to

Due to

Other Conditions: Arteriosclerotic Heart Disease Cardiac failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Atelectasis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Adyn H. Wood M. D.

Address West Baltimore General Hosp Date signed 12/3/48

VS 150

114 E

G69163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1330

G69163 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Balto.~~
(c) City or town Bowleys Quarters (If outside city or town limits, write RURAL and give town)
(d) Street No. 6317 Belair Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM G. SCHEERER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Gertrude M. Scheerer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 25th, 1900

8. AGE: Years	Months	Days	If less than one day
47		7	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Baker Proprietor
11. Industry or business

FATHER
12. Name Gottlieb Scheerer
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Holtzscheerer
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. William G. Scheerer
(b) Address Box 314 Route 15. Balto. 20

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/6/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Rawalin Funeral Home
(b) Address 7401 Belair Rd.

19 DEC 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 1948, at 9:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 1948 to 12/2 1948, and that I last saw him alive on 12/2 1948.

Immediate cause of death: Respiratory failure — Duration

Due to 1. uremia

2. malignant hypertension

Due to 3. Hydronephrosis - ureter

4. Pyelonephritis - left.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pyelonephritis

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. L. J. Finkell

Address F. S. H. Date signed M. 11/2/48 D.

VS 153

G69164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 F

Registered No. G69164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 Pelham Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Pelham Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA C. DIEPOLD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Peter J. Diepold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1864

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Michael Flierl
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Andrew Endres
(b) Address 2808 Pelham Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) DEC 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2nd, 1948 19 , at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1948 to Dec 2 1948.
and that I last saw h alive on Dec 2 1948.

Immediate cause of death Carcinoma of the liver — Duration 1 yr.

Due to

Due to

Other Conditions arteriosclerosis — 10 yr.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 3165 Belair Rd Date signed 12-3-48

VS 150

X

G69165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. G69165

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2045 W. Fayette St.
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Flagship Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Mrs Francis Anna Moore~~ Anna Frances Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	D.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1885

8. AGE: Years	Months	Days	If less than one day
63	5	5	hr. min.

9. Birthplace Frenesburg Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Tittman
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Vogl
15 Birthplace Pa.

16 (a) Informant Mr Eugene Moore
(b) Address 3 Flagship Rd, Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) [illegible] 4 – 1948 (b) Lentington Williams Md
(Registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 · 3 1948, at 1-30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11: 19 1948, to 12 · 3 1948, and that I last saw her alive on 12 · 3 1948.

Immediate cause of death Pulmonary Embolism — **Duration**

Due to Post-Operative

Due to Cholecystectomy

Other Conditions Thyroidectomy

(Include pregnancy within 3 months of death)

Date of operation 1) 11·22·48 2) 11·29·48

Major findings of operations: 1st Cholecystitis with Cholelithiasis. 2nd Adenoma of Thyroid

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. O'Callaghan. M. D.

Address Bon Secour Hosp. Date signed 12-3-48

VS 199

G69166

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. G69166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Park ave
(c) Hospital or institution:
Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 St Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Lamping

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1871

8. AGE: Years	Months	Days	If less than one day
77	3	18	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clemens Lamping
13. Birthplace Ohio

MOTHER
14. Maiden Name Helen Starr
15 Birthplace Balto. Md.

16 (a) Informant Emily R. Lamping
(b) Address 1800 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6 1948 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Green Mount
Location Balto., Md.

18 (a) Funeral director Henry W. Jenkins Son Co
(b) Address Mec 4908 York Rd.

19 (a) DEC 4 - 1948 (Date received by registrar) Hunter for Williams M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1948, at 2:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to Dec. 4, 1948
and that I last saw her alive on Dec. 3, 1948.

Immediate cause of death	Duration
Myocardial failure	2 days
Due to old age	
Due to cerebral arteriosclerosis	
Other Conditions Mild hypostatic pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 31 E. North Ave. Date signed 12/4/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

669167 94a

Registered No. 669167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore Ferndale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Eugenia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PATHICK V. OSTROSKY (e.w.)

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-6600

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Gladys C. Ostrosky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1899

8. AGE: Years	Months	Days	If less than one day
48 48	11	10	hr. min.

9. Birthplace Southport, Connecticut
(Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business National Biscuit Co.

FATHER
12. Name Frank Ostrosky
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant: Delores Ostrosky
(b) Address 110 Eugenia Ave. Ferndale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

DEC 5 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1948, at 10:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12/2/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

Registered No. 15

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADA P. LEWIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1896

8. AGE: Years	Months	Days	If less than one day
52	2	2 9	hr. min.

9. Birthplace Goldsboro, North Carolina
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Major Lewis

13. Birthplace Goldsboro, North Carolina

MOTHER 14. Maiden Name Smithie Fields

15. Birthplace Goldsboro, North Carolina

16 (a) Informant Miss Beatrice Lewis

(b) Address 1809 Park, Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1848 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Glen Burnie, Md.

18 (a) Funeral director

(b) Address Glen Burnie, Md.

19 (a) DEC 5 - 1948 (Date rec'd by registrar) (b) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 19 48 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 19 47 to Dec. 2 19 48. and that I last saw h[illegible] alive on Dec. 1, 1948.

Immediate cause of death	Duration
Carcinoma of Breast	
Due to Metastatic Carcinoma of Liver	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Nov. 1947

Major findings of operation Carcinoma (Scirrus) of Breast

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel C. Wolfe M. D.

Address 1331 E. North Ave. Date signed 12-4-48

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS 150

G69169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G69169 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Woodhome Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Woodhome Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE SUBLETT (Sublet)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 26, 1898

8. AGE: Years 49 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Klinefelter
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Davis Funeral Home
(b) Address Ambler, Pa

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12 4 48 (month) (day) (year)
(c) Cemetery or crematory Ambler Pa
Location

18 (a) Funeral director Wm Cook, Inc
(b) DEC 5 1948 1217 St. Paul St.
19 (a) DEC 6 1948 Lustington Williams M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1948, at 6:55 P M

21. I certify that I took charge of the remains described above, held an Inspection + Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12/3/48 MP

Physicians: please write the causes of death clearly and legibly. Space is especially important. Do not abbreviate. Do not use terms of mode of dying, such as heart failure, asthenia, anemia, uremia, etc., alone. Be sure cause, or causes, of death are entered in items 21 and 22.

VS 151

G69170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G69170 Registered No.

479540

52B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MAINE, (b) County
(c) City or town Presque, Isle. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frankie Hopkinson,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	married

6 (b) Name of husband or wife Grenville Hopkinson
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr) 1-12-91

8. AGE: Years	Months	Days	If less than one day
57	10	23	hr. min.

9. Birthplace Canada (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Roland Steeves
13. Birthplace Canada

MOTHER
14. Maiden Name Margaret Quigg
15. Birthplace Canada

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-5-48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Presque Isle Maine

18 (a) Funeral director Earl B. Mortensen
(b) Address 403 E. 25th St

DEC 5 1948

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1948, at 12 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-1948 to 12-4-1948 and that I last saw her alive on 12-4-1948.

	Duration
Immediate cause of death: Pulmonary Embolism (Massive)	Immediate
Due to: Pelvic Thrombophlebitis	3 wks
Due to: Papillary Carcinoma Bladder, with Total Cystectomy, Bilateral Ureterostomies	3 mos
Other Conditions: Anastomosis	3 mos

(Include pregnancy within 3 months of death)

Date of operation (1) Nov 9 (2) Nov. 21

Major findings of operation: Carcinoma Bladder

of autopsy: Pulmonary Embolism

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Everett Hanson, M.D.
Address Johns Hopkins Hosp. Date signed 12/4/48 M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69171 G69171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 H

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. Women Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County
(c) City or town Easton.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Rock St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Jane Bransford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife William Bransford
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) Dec. 5. 1926

8. AGE: Years	Months	Days	If less than one day
22	0	0	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Canaday
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy Kelly
15. Birthplace Virginia

16 (a) Informant William Bransford
(b) Address Easton - Penn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec-6 1948 (month) (day) (year)
(c) Cemetery or crematory St. James
Location Hamilton Md.

18 (a) Funeral director Landon M. Burris
(b) Address Sparks, Md

19 (a) DEC 5 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5. 1948 at 2 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1948 to Dec. 5. 1948. and that I last saw her alive on Dec. 5 1948

Immediate cause of death	Duration
Uremia	
Due to Congenital Kidney Disease	Life
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Congenital Kidney Dis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George H. Lehmann M.D.
Address Hosp. Women Md Date signed Dec. 5. 48

VS 180

Lehmann

G69172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

Registered No. G69172

Please write plainly in ink. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5542 Gwynn Oak Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5542 Gwynn Oak Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Litman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1887

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Sol Litman
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Sam Litman
(b) Address 3602 Mohawk Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5/48 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 DEC 5 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1948, at 7.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1941, to Dec 3 1948, and that I last saw h IM alive on Nov 3 1948.

Immediate cause of death	Duration
Coronary occlusion	10 min
Due to Hypertensive cardiovascular Disease + Generalized arteriosclerosis.	7 years
Due to	
Other Conditions Carcinoma Rectum resected 1944 (Include pregnancy within 3 months of death)	

Date of operation 1944

Major findings of operation: Carcinoma rectum (no trouble since operation)

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice Feldman Jr M. D.
Address 817 St. Paul St. Date signed 12/4/48

VS 150

937

G69173 ✓ G69173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

838

Registered No.

Physicians: please write the causes of death clearly and legibly. Filling write & print correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2220 Lynhurst Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2220 Lynhurst Ave

(If rural give location)

(e) Citizen of foreign country? yes (Yes or No)

If yes, name country

3 (a) FULL NAME Morris C. Caplan (MORRIS C. CAPLAN)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-22-9772

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife Lena O. Caplan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2 / 1885

8. AGE: Years 63 | Months 6 | Days 2 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Proprietress

11. Industry or business

FATHER

12. Name Jacob Caplan

13. Birthplace Russia

MOTHER

14. Maiden Name ?

15. Birthplace Russia

16 (a) Informant Lena O. Caplan

(b) Address 2220 Lynhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6/48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location Balto. & Conkling Sts

18 (a) Funeral director Chevrolea

(b) Address 2132 Reisterstown Rd

DEC 5 1948

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, MD

MEDICAL CERTIFICATION

DATE OF DEATH Dec. 4, 1948, at 7:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16, 1948, to Dec. 4, 1948. and that I last saw him alive on Dec. 2, 1948.

	Duration
Immediate cause of death: Heart failure	One mo
Due to: Cerebral thrombosis with aphasia + motor + sensory impairments	5 mo.
Due to: Hypertension (arterial)	one year
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Maurice E. Shamer M. D.

Address 3302 W. North Ave. Date signed 12/4/48

VS 150

X

G69174

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G69174
Registered No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison Street + Linden Avenue
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ½
(e) Length of stay in Baltimore (yrs., mos., or days) 67 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 Main Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE C GORE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Rambert Carroll Gore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1881

8. AGE: Years	Months	Days	If less than one day
67	2	1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Lauber
13. Birthplace Germany

MOTHER
14. Maiden Name Anna C Kuhlman
15. Birthplace Baltimore

16 (a) Informant Rambert Gore
(b) Address Reisterstown

17 (a) Burial (b) Date thereof Dec 7-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md

18 (a) Funeral director Wm Berryman & Sons
(b) Address Reisterstown, Md

19 (a) DEC 5 - 1948 (b) Huntington Willis, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1948, at 1:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1948 to 12-4 1948, and that I last saw her alive on 12-3 1948.

	Duration
Immediate cause of death Cardio-Respiratory failure	48 hrs
Due to Hypertensive Cardio-vascular disease with	15 years
Due to cerebral accident	22 days
Other Conditions Rt hemiplegia. Left breast, scirrhous carcinoma	22 days

(Include pregnancy within 3 months of death)

Date of operation 11/10/48
Major findings of operation: Scirrhous carcinoma of left breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marguerite Louise Candler M. D.
Address Mayfield Gen'l Hosp. Date signed 12-4-48

VS 190

G69175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G69175

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4704 Althea Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4704 Althea Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marguerite Virginia Apsley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph W Apsley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 1864

8. AGE: Years	Months	Days	If less than one day
84	4	19	hr. min.

9. Birthplace Kent Co. Md.
(Town, county, and state)

10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John A Hersch
13. Birthplace Lynn Mass

MOTHER
14. Maiden Name Marguerite Scott
15. Birthplace Baltimore Md.

16 (a) Informant Iona A Vesper
(b) Address 4704 althea Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7 1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Harry T. Annacock
(b) Address 4704 Ridgewood Ave.

19 (a) DEC 5 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1948, at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to 12/4 1948 and that I last saw him alive on 12/3 1948.

Immediate cause of death: Acute Nephritis — Duration 1 mo
Due to: Ch. Interstitial
Due to: arteriosclerosis
Other Conditions: Ch. Myocarditis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J S Hardesty M. D.
Address 3805 Belair Rd Date signed 12/4/48

VS 150

132

G69176

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30

G69176 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 Brady Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HENRY BEAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-1877

8. AGE: Years	Months	Days	If less than one day
71	8mt	18	hr. min.

9. Birthplace Virginia
Porter (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Mary ?
15. Birthplace Virginia

16 (a) Informant Mary Bean
(b) Address 1738 Brady Avenue

17 (a) Burial (b) Date thereof 12-6-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L Bowser Son
(b) Address 106 W Montgomery St

19 (a) DEC 5 - 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1948, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry Inspection & thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease
Syphilitic aortitis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-2-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69177 ✓ G69177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No. _____

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 330 St Dunstans
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltcity
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 330 St Dunstans (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Dr. Earl LeRoy Burky

3 (b) If veteran, name war W.W.1 —

3 (c) Social Security Account No. none

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary D.N. Burky

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) April-11-1898

8. AGE: Years 50 | Months 7 | Days 23 | If less than one day: hr. ____ min. ____

9. Birthplace Reading Pa (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business Medicine

FATHER
12. Name Geo. F. Burky
13. Birthplace Penna

MOTHER
14. Maiden Name Louisa Steiner
15. Birthplace Penna

16 (a) Informant Mary D.N. Burky (wife)
(b) Address 330 St Dunstans

17 (a) Cremation (Burial, cremation, or removal) **(b) Date thereof** 12-6-48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Stewart Memple
(b) Address [illegible] Baltimore Md.

19 (a) DEC 5 - 1948 (Date rec'd by Registrar) **(b)** [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1948, at 3 22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to Dec. 4 1948
and that I last saw him alive on Dec. 4 1948

Immediate cause of death Carcinoma of larynx — **Duration** 9 mos.

Due to _____

Due to _____

Other Conditions Chronic bronchitis

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature John H. Dryacher

Address 1025 N. Calvert St. Date signed 12/5/48.

VS 150

X

G69178 BALTIMORE CITY HEALTH DEPARTMENT G69178

CERTIFICATE OF DEATH

50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland E Monument Lt.
(b) Street address 2904 Keyworth Ave
(c) Hospital or institution:
Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Keyworth Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN FRANKLIN WEISSENBORN

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-7073

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1948 at 5:40 PM

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-15-07

8. AGE: Years 40 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace Conn.
(Town, county, and state)

10. Usual Occupation Secretary
11. Industry or business Government

FATHER
12. Name [illegible] Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Mrs. Fannie Franklin
15. Birthplace Hungary

16 (a) Informant Fannie Franklin
(b) Address 2904 Keyworth ave

17 (a) Burial (b) Date thereof 12-5-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Friendship Cem

18 (a) Funeral director Jack Lewis Inc
(b) Address 3600 Eutaw Place

DEC 9 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1948 to 12-2 1948 and that I last saw her alive on 12-2 1948

Immediate cause of death
Generalized carcinomatosis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin F Silverman M. D.
Address Sinai Hosp. Date signed 12-2-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 193

276175
G69179

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G69179

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David J. White

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Fannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-21-81

8. AGE: Years	Months	Days	If less than one day
67	7	13	hr. min.

9. Birthplace Germany ?
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Henry White -
13. Birthplace Germany

MOTHER
14. Maiden Name Matilda ?
15. Birthplace Germany

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem.
Location Baltimore

18 (a) Funeral director Jack Levy Inc
(b) Address 210 Eutaw Place

19 (a) 12-5-1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1948, at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1948 to Dec 4 1948 and that I last saw him alive on Dec. 4 1948

Immediate cause of death: Cerebral vascular accidents, multiple — Duration 1 wk

Due to Arteriosclerotic heart disease, Arteriosclerosis, generalized

Due to

Other Conditions Diabetes mellitus; Myocardial infarcts, multiple, remote
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Hull M. D.
Address Johns Hopkins Hosp. Date signed Dec 7 '48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

937

B.C. 48-26820
G69180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G69180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Oakfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Broth.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/2/45

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Henry Broth
13. Birthplace Newyork

MOTHER
14. Maiden Name Eunice Lubitch
15. Birthplace Balto Md

16 (a) Informant Henry Broth
(b) Address 3400 Oakfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd Harford Ave

18 (a) Funeral director Jacob Reives Inc.
(b) Address 2400 Eutaw Place

19 (a) DEC 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1945, at 2:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Dec 4 1945 and that I last saw h alive on Dec 3 1945.

Immediate cause of death Atelectasis — Duration

Due to

Due to

Other Conditions Bothradipus & dyspnea absent, horseshoe Kidney (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Allgaier M. D.
Address Sinai Hospital Date signed Dec 4/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69181

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

G69181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Colvert Sts.
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Richwood Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William P. Hughes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER
12. Name Joseph F Hughes (D)
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Farrell (D)
15. Birthplace Ireland.

16 (a) Informant James Jos. Hughes (Brother)
(b) Address Same as Deceased.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 13 E. Lexington St.

DEC 5 - 1948 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1948 at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1948 to Dec 3 1948 and that I last saw him alive on Dec. 2 1948.

Immediate cause of death	Duration
Pneumonia Lobar	2 days
Due to Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No abuse

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify home, farm, place) While at work?
(e) Means of injury

23. Signature
Address Lutherville, Md. Date signed 12/3/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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G69182

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G69182

Registered No. 8

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 Light St
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 Marshall Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph S LANASA Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Theresa DARNICAK **6 (c) If alive, give age** years

7. Birth date of deceased (mo., day, yr.) 12/8/1877

8. AGE: Years	Months	Days	If less than one day
70	11	25	hr. min.

9. Birthplace Sicily
(Town, county, and state)

10. Usual Occupation Fruit Dealer

11. Industry or business Cross St Market

FATHER
12. Name Michael Lanasa
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Gentile
15. Birthplace Italy

16 (a) Informant Mrs Stephen Mondia
(b) Address 205 Williams St

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 12/6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Pulaski Highway

18 (a) Funeral director J. J. Zahey & Sons
(b) Address 1248 North Ave Baltimore, Md

DEC 5 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/48 19 & 54 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 12/2/48

Please write answers to all questions. Be sure that the information you give is correct and complete. Physicians: please write the causes of death clearly and legibly. Cause of death is especially important.

VS 191

G69183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G69183

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Argonne Drive
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME ETHEL D. REED

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 1898

8. AGE: Years	Months	Days	If less than one day
50	2	–	..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Home Maker

11. Industry or business

FATHER — 12. Name	Thomas W. Mooney
FATHER — 13. Birthplace	Baltimore
MOTHER — 14. Maiden Name	Katherine Vogt
MOTHER — 15. Birthplace	Baltimore

16 (a) Informant Mr James J Reed
(b) Address 1303 Argonne Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Bedemeyer

18 (a) Funeral director Wm. J. Fogg Sons
(b) Address 1818 Eutaw St
Registrar Washington Williamson, Mgr.

19 DEC 5 - 1948 (Date rec'd by Registrar) (Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1948, at 7:35 P.M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull
intracranial hemorrhage

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 9/2

(a) Date of injury 12-2-48 at 7:00 P. M.
(b) Where did injury occur? Loch Raven & Roundhill Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature ..... M.D.
Medical Examiner

Date signed 12-3-48

G69184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G69184 Registered No. 84

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 N. Calhoun Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY W. EPPS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Martha Epps

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1877

8. AGE: Years 71 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Crew, Virginia (Town, county, and state)

10. Usual Occupation General contracting.

11. Industry or business Self.

FATHER
12. Name Daniel Epps
13. Birthplace Notway, Virginia

MOTHER
14. Maiden Name Lydie
15. Birthplace Notway, Virginia

16 (a) Informant: William H. Epps
(b) Address 409 N. Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/48 (month) (day) (year)
(c) Cemetery or crematory Mount Zion
Location Lakeland, Md.

18 (a) Funeral director Joseph A. Lively
(b) Address 661 W. Barre St.

19 (a) DEC 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 19 48, at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Transverse myeolitis of cervical cord

Due to dislocation of cervical vertebrae

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 16-1
(a) Date of injury 11-26-48 at 5:00 P. M.
(b) Where did injury occur? Rear of 622 N. Carrollton Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Rear of home While at work? Yes
(d) Means of injury Fell from 2nd story porch when banister broke

23. Signature [signature] M.D. Medical Examiner
Date signed 12-3-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G69185

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Registered No. G69185

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 Gittings Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 E. 33rd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH A KAVANAUGH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Benedict G. Kavanaugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/16/58

8. AGE: Years	Months	Days	If less than one day
90	0	18	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel J. McCormick
13. Birthplace Ireland

MOTHER
14. Maiden Name Winifred Dalton
15. Birthplace Ireland

16 (a) Informant Benjamin J. Kavanaugh
(b) Address 1524 E. 33rd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. H. Weaver and Son
(b) Address 805 W. Calvert St.

19 DEC 5 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Dec. 1948 at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to 4 Dec. 1948
and that I last saw h[illegible] alive on 2 Dec. 1948

Immediate cause of death Arteriosclerotic Cardio-Vascular Disease — Duration 10 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kammerer
Address 501 Sheridan Ave Date signed 5 Dec 48

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X

G69186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69186

467

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + CALVERT STREETS
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County Baltimore
(c) City or town LUTHERVILLE
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. THOMAS G. CAMPBELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife THOMAS G. CAMPBELL
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 6/8/1887

8. AGE: Years	Months	Days	If less than one day
61	5	26	..... hr. ..... min.

9. Birthplace ALABAMA (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name BRAD FORD DUNHAM
13. Birthplace GEORGIA

MOTHER
14. Maiden Name SOPHIE DUNNINGTON
15 Birthplace MARYLAND

16 (a) Informant MR. THOMAS G. CAMPBELL
(b) Address LUTHERVILLE, MARYLAND

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Frederick Rd., Balto. Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) DEC 5 - 1948 (Date rec'd by registrar) (b) Registrar

Burlington Funeral Service, Inc.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4 1948, at 3:19 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28 1948 to 12-4 1948 and that I last saw HER alive on 12-4 1948.

Immediate cause of death	Duration
Retroperitoneal metastatic Carcinoma of abdomen	
Due to Carcinoma of rectum	
Due to Retroperitoneal	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8-14-48
Major findings of operation: CARCINOMA OF RECTUM.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P. Moore M. D.
Address Union Memorial Hospital Date signed 12-4-48

VS 150

correct age is especially important and should be obtained from a birth certificate whenever possible. Please print plainly with pen and ink.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G69187 CERTIFICATE OF DEATH 94a G69187

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4149 Eierman Avenue St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

If U. S. Veteran specify WAR

2. FULL NAME Harry A.Hill

(a) Residence: No. 4149 Eierman Avenue St., Ward. S.S.No. ?

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lola M.Hinkle S.S.-217-09-7014

6. DATE OF BIRTH (month, day, year) Feb.12th.,1889

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or MINS.
59	9	22 23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Contracter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Own business

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore,Md.

FATHER

13. NAME James A.Hill

14. BIRTHPLACE (city or town) (State or country) Baltimore,Md.

MOTHER

15. MAIDEN NAME Metilda Prutz

16. BIRTHPLACE (city or town) (State or country) Baltimore,Md.

17. INFORMANT Mrs.Lola M.Hill --- Wife

(Address) 4149 Eierman Avenue

18. BURIAL, CREMATION, OR REMOVAL

Place Moreland Park Date 12/7/48 19

19. UNDERTAKER George J.Ruth,Inc.

(Address) 1735 Harford Avenue,Balto:Md.

DEC 6 1948 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) DECEMBER 5, 1948

22. I HEREBY CERTIFY, That I attended deceased from AUGUST 1947 to DECEMBER 1948

I last saw h.. alive on DECEMBER 4, 1948 Death is said to have occurred on the date stated above, at 6:05A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
CORONARY OCCLUSION	DEC. 3
Other contributory causes of importance CORONARY SCLEROSIS	

Was an operation performed? NO. Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) John F. Polk M. D.

(Address) 4200 Fulton Ave

OCCUPATION IS ONLY REQUESTED FOR PERSONS 10 YEARS OF AGE AND OVER

V8.8

G69188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G69188 Registered No. 88

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4906 Frederick Ave
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) X 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 Lanvale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Samuel T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 3, 1868

8. AGE: Years	Months	Days	If less than one day
80	8	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Francis C. Klunk

13. Birthplace Pa.

MOTHER 14. Maiden Name Unknown

15. Birthplace —

16 (a) Informant Mrs. Howard

(b) Address 1836 Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Geo. A. Fahey

(b) Address Baltimore & Fayette Sts.

19 (a) DEC 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Dec 1948 at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948 to 2 Dec 1948 and that I last saw h[illegible] alive on 1 Dec 1948.

Immediate cause of death: Acute Congestive Heart Failure

Due to A.S.C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl C. Royer M. D.

Address 142 W. Lanvale St. Date signed 3 Dec 48

Physicians: please write the causes of death clearly and legibly. Underlining is especially important. Please state the correct age in years.

VS 150

X

G69189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69189

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Argyle Avenue (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL J. JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1889

8. AGE: Years 59 | Months 9 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name Samuel Jones
13. Birthplace Westminister

MOTHER
14. Maiden Name Martha Field
15. Birthplace Gloucester, Virginia

16 (a) Informant John Jones
(b) Address 5419 Denmore Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director MRS. GEORGE H. HOLLAND
(b) Address 1631 Druid Hill Avenue

19 (a) DEC 5 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1948, at 4:25 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A. S. C. V. D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rayer M.D.
Medical Examiner. DJM
Date signed 12-3-48

VS 151

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G69190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G69190

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2815 Remington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Remington Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MATILDA HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alfred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1876

8. AGE: Years 72 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Caroline Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name Alice Grey
15. Birthplace Caroline Co. Va.

16 (a) Informant Mrs. Violet Dixon
(b) Address 2815 Remington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/1948 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson, Maryland

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 DEC 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

a/

20. DATE OF DEATH December 3, 1948, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945 to Dec 2 1948.
and that I last saw her alive on Dec 2 1948.

Immediate cause of death Organic Heart Disease — Duration Hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Garland Schmidt M. D.
Address 1534 Druid Hill Ave Date signed Dec 3 48

VS 150

G69191

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

Registered No. G69191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 3
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2438 Brentwood Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Edmonds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 8-28-93

8. AGE: Years 55 | Months 3 | Days 6 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel White

13. Birthplace Va

MOTHER 14. Maiden Name Frances Venable

15. Birthplace Va

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Holland

(b) Address 1631 Druid Hill Ave

DEC 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1948 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1-1948 to 12-3-1948 and that I last saw h er alive on 12-3-1948.

Immediate cause of death: Bronchopneumonia — Duration 1 wk

Due to: Post Encephalitic Paralysis — 10 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Bronchopneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard S Ross M.D.

Address Johns Hopkins Hosp Date signed 12/7/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69192

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G69192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Glyndon (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 Butler Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jessie Seabold
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife George Seabold
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr) May 29 1881

8. AGE: Years	Months	Days	If less than one day
67	6	7	hr. min.

9. Birthplace Md. Baltimore City (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Todd
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Emrick
15. Birthplace Md.

16 (a) Informant George H. Seabold
(b) Address Glyndon Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 8 1948 (month) (day) (year)
(c) Cemetery or crematory Pinard Ridge
Location Balto Co

18 (a) Funeral director J F Elam & Sons
(b) Address Reisterstown Md

19 (a) DEC 4 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 1948. at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1948. to 12/5 1948.
and that I last saw h[illegible] alive on 12/5 1948.

Immediate cause of death Cardiac failure - pulmonary Emphysema & fibrosis — Duration
Due to Irradiation
Due to Carcinoma Rt breast to metastasis Skin
Other Conditions long Syphilis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. W. Winters
Address Church Home Date signed 12/5/48

VS 150

Page is especially important. Physicians: please write the causes of death clearly and legibly. correct

9193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

G69193 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 7 Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Holly

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-0033

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	col.	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15-1903

8. AGE: Years	Months	Days	If less than one day hr.	min.
44	11	17		

9. Birthplace St. Marys. Co. Md (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Wilson Hall
13. Birthplace St. Marys. Co. Md

MOTHER
14. Maiden Name Henrietta Reed
15. Birthplace St. Marys. Co. Md

16 (a) Informant Arlean Lyntchire
(b) Address 1612 Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-48 (month) (day) (year)

(c) Cemetery or crematory
Location St. Marys. Co. Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Blankety ave

19 DEC 6 - 1948 (Date Rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1 1948, at 6:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Nov. 1948, to 1 Dec. 1948, and that I last saw h. alive on 1 Dec. 1948.

Immediate cause of death	Duration
Anopemia	1 day
Due to Pulmonary Congestion	3 wks.
Due to Hypostatic heart failure	3 wks.
Other Conditions Uremia.	3 wks.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Thill M. D.
Address Dec. 1, 1948 Date signed Dec 1, 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

69194 B C #26044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160C

Registered No. 69194

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 267½ N. Exeter St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 267½ N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Marable

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-20-48

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 2 hr. min.

9. Birthplace Balt., Balt., Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Robert Larry Marable
13. Birthplace Wilson, N.C.

MOTHER
14. Maiden Name Dora Elizabeth Patterson
15. Birthplace Baltimore, Maryland

16 (a) Informant Dora Marable (Mother)
(b) Address 267½ N. Exeter St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School NOV 22 1948
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 6 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20 1948, at 5.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1948, to 19 ; and that I never saw h i m alive on 19 .

Immediate cause of death: Suffocation — Duration: 2 hrs.

Due to Fetal membranes obstructing mouth & nose — 2 hrs.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: Not done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Cohen, M.D.
Address Balto - City Hosp Date signed 11/20/48

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G69195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3C-48-25626 30F

Registered No. G69195

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 18 14 Division st

(c) Hospital or institution Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1354 Whatcoat St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Sodonia Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: B.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/17/48

8. AGE: Years | Months | Days | If less than one day: 18 hr. 22 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Ill Born Infant

11. Industry or business

FATHER

12. Name Arthur Harris

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Sodonia Green

15. Birthplace Baltimore Md

16 (a) Informant Miss Sodonia Green

(b) Address 1354 Whatcoat St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School NOV 30 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) DEC 6 - 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18 1948, at 3:17 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17 1948 to 11/18 1948.

and that I last saw h. liv. alive on 11/18 1948.

Immediate cause of death ?

Duration

Due to Congenital Lues

Due to Untreated Secondary Maternal Lues

Other Conditions Premature

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Louise Young M. D.

Address 1100 Druid Hill Ave Date signed 12/1/48

VS 150

69196 48-25725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G69196

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Mary Ht & Calhoun Sts.

(c) Hospital or institution Franklin Square Hosp 25

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 802 Stall St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Hall —

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/28/48

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER - FATHER

12. Name Harry Thomas Hall

13. Birthplace Balto - Md.

MOTHER

14. Maiden Name Jane Fyfer

15. Birthplace Millers Town Penna

16 (a) Informant Harry T. Hall.

(b) Address 802 Stall St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School NOV 30 1948

Location

18 (a) Funeral director Commissioner of Health

(b) Address

19 DEC 6 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1948 to 11/27 1948 and that I last saw him alive on 11/27 1948

Immediate cause of death Pneumonia —

Due to atelectasis.

Due to

Other Conditions Prematurity —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 11/28/48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

21. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Dan Churchill M.D.

Address Franklin Sq. Hosp Date signed 11/28/48

VS 150

1093

69197 BC- 48-26376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G69197

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor Ave
(c) Hospital or institution:
West Balto General Hosp 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6108 Old Harford Rd # 14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Anthony Patchak

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/27/48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Anthony F Patchak
13. Birthplace Hazelton Pa

MOTHER
14. Maiden Name Helen A. Marinock
15. Birthplace Milnesville Pa

16 (a) Informant Mrs Helen Patchak
(b) Address 6108 Old Harford Rd # 14

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 30 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) DEC 6 – 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1948, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1948 to 11/29 1948, and that I last saw h e alive on 11/29 1948.

Immediate cause of death	Duration
Intestinal Hemorrhage	
Due to	
Due to	
Other Conditions Atelectasis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S A Alessi M. D.
Address 11 East Chase St - 2 Date signed 11/29/48

VS 189

69198

BC-48-25382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G69198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Smithson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Smithson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl WILLIAMS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 29 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1948 at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Atelectasis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward Boyd M.D.
Medical Examiner.
Date signed 11/20/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

69199 B.C. 48-28871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 69199

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Streets
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 W. Henrietta St. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Gee

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/18/48

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace

MOTHER
14. Maiden Name Beatrice Gee
15. Birthplace Md.

16 (a) Informant Beatrice Gee
(b) Address 16 W. Henrietta St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 30 1948

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1948, at 9.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18/ 1948 to 11/23 1948.
and that I last saw h[illegible] alive on 11/23 1948.

Immediate cause of death Resp. failure
Due to atelectasis
Due to bronchial obstruction — aggravated regurgitated food
Other Conditions 2 lb 1½ oz. premature
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. Menschenfreund M.D.
Address University Hosp. Date signed 11/23/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

161a

G69200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G69200
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Provident Hospital 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2133 Maryland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BAILEY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/12/48

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 29 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 19 48, 5:35 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Atelectasis.
Prematurity.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed November 15, 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 669201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1320 N. Bond St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANThony RiCHARDSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-01

8. AGE: Years	Months	Days	If less than one day
47	1	23	hr. min.

9. Birthplace RALEIGH, N. C.
(Town, county, and state)

10. Usual Occupation HUCKSTER.

11. Industry or business

FATHER
12. Name ?
13. Birthplace N. C.

MOTHER
14. Maiden Name ?
15. Birthplace N. C.

16 (a) Informant JANIE BUTLER
(b) Address 1320 N. Bond ST.

17 (a) BORIAL (b) Date thereof 12-6-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY
Location AA. COUNTY

18 (a) Funeral director Joseph L. Locke Jr
(b) Address 1364 N. Central Ave

19 (a) DEC 6 - 1948 (b) Clarington Williams M.D.
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3-1948 at 3:15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11/20 1948 to 12/3 1948 and that I last saw h[illegible] alive on 12-3 1948.

Immediate cause of death: Lobar Pneumonia — Duration 2 wks

Due to Colds + Exposure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. R. Blake M.D.
Address 1602 N. Carolina Ave. Date signed 12/7/48

VS 150

69202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 66[illegible]02

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Caney St
(c) Hospital or institution: Good Samaritan Hospital 11 - 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 865 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Chesley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	

6 (b) Name of husband or wife FLORENCE (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-5-1873

8. AGE: Years	Months	Days	If less than one day
75	9	28	hr. min.

9. Birthplace BALTIMORE, Md (Town, county, and state)
10. Usual Occupation PENSIONER
11. Industry or business

FATHER
12. Name ?
13. Birthplace Md

MOTHER
14. Maiden Name ELLA P. GILPIN
15. Birthplace NA.

16 (a) Informant MARY Chesley
(b) Address 865 LINDEN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-7-48 (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY
Location A.A. County, Md

18 (a) Funeral director Joseph L. Lockard
(b) Address 1300 N. Central Ave

19 (a) DEC 6 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3/48 19 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/30/48 19 to 12/3/48 19, and that I last saw h[illegible] alive on 12/3/48 19

Immediate cause of death	Duration
Arteriosclerosis	unknown
Due to Arteriosclerosis	"
Due to Hypertension	2
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wm P Dorn M. D.
Address 1 W Eden Ave Date signed 12/6/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 159

9203 Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 669203

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos 5 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Kinsey Cox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?

8. AGE: Years	Months	Days	If less than one day
? 80			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business General

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

CERTIFICATION APPROVED BY
For J. R. Davis
M.D.
DEPUTY CHIEF MEDICAL EXAMINER

16 (a) Informant Leon Goldberg
(b) Address Cockeysville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 8, 1948 (month) (day) (year)
(c) Cemetery or crematory Bosl
Location Cockeysville

18 (a) Funeral director Lander M. Brooks
(b) Address Sparks, Md.

19 (a) DEC 8 - 1948 Huntington Williams, M.D. Registrar
(Date received by reg.)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1948 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1948, to Dec 5 1948, and that I last saw h[im] alive on December 4 48.

Immediate cause of death
Cardiac Failure
Due to Arteriosclerotic Cardiovascular Disease
Due to
Other Conditions Fracture neck left femur
(Include pregnancy within 3 months of death)

Duration

Date of operation 12/2/48
Major findings of operation: Fracture left femur
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept. 30 1948 at about 10:30 AM
(c) Where did injury occur? Cockeysville Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped & fell to floor
23. Signature Frank E. Gardner M. D.
Address University Hospital Date signed 12/3/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 54 B

Registered No. 669204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution: Redwood & Greene Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) ~~City or~~ town Severn
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Phelps

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Mar. 1st 1908

8. AGE: Years	Months	Days	If less than one day
40	9	4	hr. min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. ~~Employer~~ Sanitary Commission

FATHER
12. Name James A Phelps
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia Durner
15. Birthplace Md.

16 (a) Informant Mrs. Ruth Seala
(b) Address Severn Md.

17 (a) Burial (b) Date thereof 12-8-48
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery or ~~Crematory~~ Private Burying Grounds
Location Severn Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b) Huntington Williams M.D.
(Date received by Local Registrar) Registrar

DEC 6 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1948, at 6 41 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1948 to Dec 5 1948 and that I last saw h/m alive on Dec 5 1948.

Immediate cause of death	Duration
Malignant Tumor of Spinal Cord	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Auld M. D.
Address Univ. Hosp Date signed 12/5

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69205

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124B

Registered No. G69205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Street
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 No. Howard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Tolley A. Biays

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Helen Mary Biays
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1876

8. AGE: Years 72 | Months 4 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore, Baltimore Md. (Town, county, and state)

10. Usual Occupation Consulting Engineer

11. Industry or business

FATHER
12. Name Mr. George Biays
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Jane Price
15 Birthplace Md.

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12-7-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date received by local registrar DEC 8 1948 (b) Registration No. Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1948, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1948 to Dec 4 1948, and that I last saw h~~im~~ alive on Dec 4 1948.

Immediate cause of death Cirrhosis of liver

Duration

Due to

Due to

Other Conditions Incipient inguinal hernia, bilat.
(Include pregnancy within 3 months of death)

Date of operation 11-24-48

Major findings of operation: Cirrhosis of liver.

of autopsy: Cirrhosis of liver.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles H. Watt, Jr. M.D.
Address Union Memorial Hospital Date signed 12/7/48

X

M M. 123470
669206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. 669206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2MOS.
(e) Length of stay in Baltimore (yrs., mos., or days) 54 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 E. FAIRMOUNT AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THEODORE BRONISKY.

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-24-7827

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWED

6 (b) Name of husband or wife AMELIA (DEC)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/4/1866

8. AGE: Years	Months	Days	If less than one day
82 YRS.	8	1	hr. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name FRITZ BRONISKY.
13. Birthplace GERMANY

MOTHER
14. Maiden Name HONOR ?
15. Birthplace GERMANY

16 (a) Informant BALTIMORE CITY HOSPITALS.
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A-6 County Md

18 (a) Funeral director Wilhelm Godwin
(b) Address 1219 Druid Hill Ave

19 (a) DEC 6 1948 (month) (day) (year) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH 12-5 1948, at 2.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3- 1948 to 12-5 1948.
and that I last saw him alive on 12-5- 1948

Immediate cause of death	Duration
~~Bronchopneumonia~~ Pyelonephritis, uremia	2 days.
Due to Benign hypert. prostate	yrs
Due to	
Other Conditions ~~Prostatectomy~~ Bronchopneumonia	2 days

(Include pregnancy within 3 months of death)

Date of operation 12-2-48
Major findings of operation: Adenocarcinoma of prostate, Benign hypertr. of prostate above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically. over

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature S A Pitchford MD M. D.
Address 4940 Eastern Ave Date signed 12-5-48

V S 150

THESE WHITE CERTIFICATES, with CARBONS, are sent to undertakers. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

669207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 669207

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Any unknown or not applicable item should be indicated by a dash. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 SOUTH PAYSON (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME RALPH JUSTICE BAYLEY

3 (b) If veteran, name war —
3 (c) Social Security Account No. 219-03-6913

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife Mrs. Ralph Bayley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 15, 1884

8. AGE: Years	Months	Days	If less than one day
64	6	20	hr. min.

9. Birthplace VIRGINIA (Town, county, and state)
10. Usual Occupation CARPENTER
11. Industry or business

FATHER
12. Name James A Bayley
13. Birthplace Va

MOTHER
14. Maiden Name Mary E Chandler
15. Birthplace Va

16 (a) Informant FANNIE BAYLEY (WIFE)
(b) Address SAME

17. Buried (Burial, cremation, or removal) (b) Date thereof 12/6/48 (month) (day) (year)
(c) Cemetery or crematory Mt Lincoln
Location Gladys Spring Rd
18 (a) Funeral director Mahoney & Dore
(b) Address 624 E Fayette St
19 (a) — (b) Huntington Williams, M.D. Registrar
(Name and title of person supplying information)

DEC 6 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 DEC 1948, at 7 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 NOV 1948 to 5 DEC 1948, and that I last saw him alive on 4 DEC 1948.

Immediate cause of death
CARDIAC ARREST —
DUE TO: POSTERIOR MYOCARDIAL INFARCTION, MASSIVE, RECENT
WITH MURAL THROMBUS OF RIGHT VENTRICLE AND THROMBOTIC PULMONARY EMBOLI, WITH PULMONARY INFARCTS OF RIGHT LUNG

Duration
2 MIN
2+ WEEKS
ABOUT 2 WEEKS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: ABOVE CAUSE OF DEATH

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald L. England M. D.
Address Maryland Gen Hosp Date signed 5 Dec 48

X

Referred . Exam. Case
Released to Hosp
134229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 169208

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H. Pfarr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Barbara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26 1884

8. AGE: Years	Months	Days	If less than one day
64	10	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business Tailoring

FATHER
12. Name Joseph V. Pfarr
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Charlotte Nash
15. Birthplace Balto. Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12-7-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) DEC 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1948, at 5:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3-1948 to 12-4 1948. and that I last saw h~~im~~alive on 12-4-1948.

Immediate cause of death	Duration
Respiratory and cardiac arrest	
Due to Cerebral hemorrhage	
Due to Hypertensive and arteriosclerotic cardio-vascular disease	
Other Conditions (Include ~~pregnancy~~ if within 3 months of death)	

Date of operation

Major findings of ~~CERTIFICATION APPROVED BY~~ ~~Howard A. Kelly, M.D.~~ for John R. Davis, M.D. CHIEF OR ASST. MEDICAL EXAMINER
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes (~~violence~~), fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William W. Winternitz M.D.
Address Johns Hopkins Hosp signed 12-4-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 199 To be approved by Med Examiner

669-09

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

669-09 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710-Woodyear St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710-Woodyear
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Jones.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4 1879

8. AGE: Years 69 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER 12. Name George Jones

13. Birthplace S. C.

MOTHER 14. Maiden Name

15. Birthplace S. C.

16 (a) Informant Ethel Jones

(b) Address 710-W Woodyear St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem.

Location

18 (a) Funeral director A. Halstead

(b) Address 918-Druid Hill Ave

19 (a) DEC 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2- 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1948, to Dec. 2 1948, and that I last saw him alive on Dec 2 1948.

Immediate cause of death Cancer of Rectum — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? - While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Garland Ahrens M. D.

Address 1534-Druid Hill Ave Date signed Dec 2 1948

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

X

69210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 69210

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Hennenman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA HECK EVANS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife WILLIAM H. Evans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-28-99

8. AGE: Years	Months	Days	If less than one day
49	9	6	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name George W. Heck.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma V. Bungan
15. Birthplace Balto. Md.

16 (a) Informant Wm. H. Evans
(b) Address 1811 Hennenman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6-48 (month) (day) (year)
(c) Cemetery or crematory Balto. Ger.
Location North Ave. & Gay St.

18 (a) Funeral director John J. Miller
(b) Address 2334 Jefferson St.

19 DEC 6 - 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC - 3 1948, at 8:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from DEC - 1 1948, to DEC - 3 1948, and that I last saw HER alive on DEC - 3 1948.

Immediate cause of death	Duration
HEART FAILURE (Sudden)	
Due to Poss COMMON DUCT STONE ? ? ?	
Due to	
Other Conditions HYPERTENSIVE C.V.D.	

(Include pregnancy within 3 months of death)

Date of operation -
Major findings of operation: NONE PERFORMED
of autopsy: NONE PERFORMED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Merle Sundell Schaer M. D.
Address Sinai Hospital Date signed 12-3-48

VS 193

126

G69211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rodleigh Nursing Home
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine B. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Andrew J. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31-1884

8. AGE: Years	Months	Days	If less than one day
64	4	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name John Henneman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Litz
15. Birthplace Balto. Md.

16 (a) Informant Andrew H. Miller
(b) Address 131 N. Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director John A. Miller
(b) Address 232 E. Jefferson St.

19 (a) DEC 6 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to Dec. 3 1948
and that I last saw her alive on Nov. 15 1948

Immediate cause of death
Due to Cerebral Hemorrhage. Duration
Due to Had a Cerebral Accident Heard in Medulla on May 1947. Heard
Due to Hypertensive Cardio Vascular
Other Conditions Disease

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. B. Stevens
Address 3400 Eastern Ave Date signed 12/9/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 E. Hoffman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 E. Hoffman St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Neumann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Catherine Neumann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1866

8. AGE: Years	Months	Days	If less than one day
82	10	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Wagon builder-retired
11. Industry or business

FATHER
12. Name John Neumann
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Hartman
15. Birthplace Germany

16 (a) Informant Frank Neumann
(b) Address 1313 Aisquith St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) DEC 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address 4508 Harford Rd.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH December 2, 1948, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1941 to 12-2 1948
and that I last saw h[illegible]ive on 12-1-1948.

Immediate cause of death
(a) Acute Myocarditis — Duration 1 Year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4508 Harford Rd. Date signed 12-7-48

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Entry of information must be complete and correct as far as known. Answer each question. If none, write "None." Where date is required, if unknown, state approximate date. If not delivered within 8 days after death, the physician in charge of case or the coroner is required to report the cause of death. Underlining and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G69213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4101 Marx Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Marx Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie E. Zeiler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George A. Zeiler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1881

8. AGE: Years	Months	Days	If less than one day
67	7	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name David Klingelhoefer
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Vauble
15. Birthplace Germany

16 (a) Informant Mrs. Naomi Loverdi
(b) Address 4101 Marx Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Ulm's Funeral Home
(b) Address 2008 Orleans St

19 (a) Dec 6 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1948 19 , at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1942 to Dec 3 1948, and that I last saw h alive on Dec 3 1948.

Immediate cause of death Cerebral Hemorrhage — Duration Aug 13, 1948

Due to Arteriosclerosis Diabetes Mellitus — 1945

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 6217 Harford Rd Date signed 12/7/48

VS 150

X

G69214

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

Registered No. G69214

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 Hortonia Rd
(c) Hospital or institution: The Mount
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Mortwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Pearce

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1872

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not known
13. Birthplace Russia

MOTHER
14. Maiden Name Not known
15. Birthplace Russia

16 (a) Informant Son Pearce - Son
(b) Address 619 S. Carolina St

17 (a) Burial (b) Date thereof 12-6-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location E. Balto St

18 (a) Funeral director Jack Levin Son
(b) Address 2400 Eutaw Pl

19 (a) DEC 6 - 1948 Huntington Williams M.D.
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1948, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 46, to Dec 5 19 48, and that I last saw him alive on Dec. 4 1948.

Immediate cause of death Uremia

Due to Arteriosclerosis

Due to Pneumonitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature V. G. Rhodes

Address 314 - W. North Ave Date signed 12/8/48

VS 150

G69215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G69215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made on this certificate only. Do not use abbreviations. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 61 days
(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 510 N. Park Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: GUS NUNN - (Nakros)

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen Nunn

6 (c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): May 21, 1891

8. AGE: Years: 57 | Months: 6 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Greece
(Town, county, and state)

10. Usual Occupation: Leather worker

11. Industry or business:

FATHER
12. Name: Constantine ?
13. Birthplace: Greece

MOTHER
14. Maiden Name: William Nunn
15. Birthplace: Greece

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 6-48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National Cem
Location: Baltimore Md.

18 (a) Funeral director: Lambros Funeral Homes Inc
(b) Address: 440 E. Fourth Ave. Huntington Williams, Md

19 (a) DEC 6 - 1948 (Date filed by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29 1948, at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 1948, to Nov. 29 1948, and that I last saw him alive on Nov. 29 1948.

Immediate cause of death: Lymphosarcoma — Duration: unknown

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 12/3/48

VS 150

9218 Osh 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G69216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 793 George St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Keene

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-2-02

8. AGE: Years	Months	Days	If less than one day
46	-	23	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Joseph Keene
13. Birthplace Md

MOTHER
14. Maiden Name Mary Keene
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-48 (mopth) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto, Md.

18 (a) Funeral director Charles K. Law
(b) Address 2012 Madison Ave

19 (a) DEC 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25 1948, at 3:20 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 1948, to 11-25 1948, and that I last saw her alive on 11-25 1948.

Immediate cause of death: Cerebro-vascular accident — subarachnoid hemorrhage — Duration
Due to: hypertensive cardiovascular
Due to: disease
Other Conditions: -

(Include pregnancy within 3 months of death)
Date of operation: -
Major findings of operation: -
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence at M
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury -

23. Signature J. Lee Chesney
Address Johns Hopkins Hospital Date signed 12-3-48 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3914 Woodridge Road.
(c) Hospital or institution: 16-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or ~~town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3914 Woodridge Road.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE COTTON STEHLIG.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Emil C. Stehlig.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1870.

8. AGE: Years	Months	Days	If less than one day
78	-	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Liepman Cotton,
13. Birthplace Germany.

MOTHER
14. Maiden Name Brine Hart,
15. Birthplace On boat enroute to U.S.

16 (a) Informant Mr. Tobias Cotton,
(b) Address 3914 Woodridge Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/48. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1902 Eutaw Place

19 DEC 6 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3rd. 1948 at PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1941 to Dec 3 1948. and that I last saw h Ar alive on Dec 3 1948.

Immediate cause of death	Duration
Hypostatic Pneumonia.	2 days.
Due to Cerebral Thrombosis -	6 days.
Due to Arteriosclerotic Cardio Vascular Disease	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert J. Stuckert M.D.
Address 2302 Edmondson Ave. Date signed

VS 150

69218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. 69218

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~3309 Noble St~~

(c) Hospital or institution: University Hospital 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3309 Noble St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George Stielper

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-7787

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	

6 (b) Name of husband or wife Elizabeth M. Stielper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1902

8. AGE: Years	Months	Days	If less than one day
46 46	7	11	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Packer

11. Industry or business Continental Can Co. Inc

FATHER

12. Name Leonard Stielper

13. Birthplace Maryland

MOTHER

14. Maiden Name Mary Smith

15. Birthplace Maryland

16 (a) Informant Elizabeth M. Stielper

(b) Address 3309 Noble St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director John A. Moran

(b) Address 3000 E. Baltimore St.

19 DEC 6-1948 (Date rec'd by registrar) Huntington Williams Mort

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1948, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1948 to Dec 3 1948.

and that I last saw him alive on Dec. 3 1948.

Immediate cause of death Circulatory failure — Duration

Due to Exsanguination

Due to Ca Tonsils

Other Conditions Pepsod Ulcer

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. C. Hunter, M.D. M. D.

Address Univ. Hosp. Date signed 12-3-48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

VS 153

G69219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 M

Registered No. G69219

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME OSEAR Daniel Mial

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-5890

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife MARIE Mial
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1883

8. AGE: Years	Months	Days	If less than one day
65	5	19	hr. min.

9. Birthplace Mt. Oliver, N.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joseph Mial
13. Birthplace Mt. Oliver, N.C.

MOTHER
14. Maiden Name HARRIETT Washington
15. Birthplace Mt. Oliver N.C.

16 (a) Informant Callie Hinton
(b) Address 2212 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director C. Halsted
(b) Address 2218 Druid Hill Ave.

19 DEC 6 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1948, at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1948, to Dec 3, 1948, and that I last saw him alive on Dec. 2, 1948.

Immediate cause of death	Duration
CARDIAC Failure	Day
Due to CARDIAC Decompensation	Several wks.
Due to Probable Malignancy of Gastro-Intestinal Tract	Indefinite
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 N. Franklin St. Date signed 12-3-48

VS 190

X

HH. 3. 01.

G69220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G69220

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 251
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore # 26 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3225 Sun St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Montgomery
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-4-37

8. AGE: Years	Months	Days	If less than one day
11	3	29	hr. min.

9. Birthplace Dillon S.C. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Rubin Montgomery
13. Birthplace S.C.

MOTHER
14. Maiden Name Bertha Brown
15. Birthplace S.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) DEC 6 - 1948 (Date rec'd by registrar) Huntington Williams

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3 1948, at 3:45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2- 1948 to 12-3 1948, and that I last saw her alive on 12-3 1948.

Immediate cause of death	Duration
Heart Stopped.	
Due to ? Irreversible cerebral damage.	
Due to ? heart failure.	
Other Conditions diabetic coma.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Hanson M. D.
Address Johns Hopk. Hosp Date signed 12/3/48

X

G69221 LCH - 124932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 Etting Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME SYLVIAN TYLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 1, 1907

8. AGE: Years	Months	Days	If less than one day
41	-	1	hr. min.

9. Birthplace ? Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Tyler.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Blanche Horton
15. Birthplace ?

16 (a) Informant 4940 Eastern Avenue
(b) Address B.C.H. Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) DEC 6 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/48 19 , at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28/48 19 to 12/2/48 19 , and that I last saw h im alive on 12/2/48 19 .

Immediate cause of death Myocardial Failure — Duration

Due to Intracranial Hemorrhage — Duration

Due to Hypertensive Heart Disease — Duration

Other Conditions Hypertension — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Intracranial Hemorrhage

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed

Please write plainly, with pen or pencil, and do not use ditto marks. Be sure your answer to each question is complete and correct. Space is provided for essential information; do not write in margins. Items 12 to 15, regarding parents, are especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

Huntington Williams, M.D.

G69222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G69222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 239 N. Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 239 N. Stricker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Spriggs.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John A. Spriggs
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 2, 1877

8. AGE: Years 71 | Months 3 | Days - | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Clatterse Jenifer.
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Susan Smallwood
15. Birthplace Calvert Co., Md.

16 (a) Informant Sarah Brown.
(b) Address 239 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 6 - 1948 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1948 at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased Oct 24 1948 to Dec 2 1948 and that I last saw her alive Dec 2 1948.

Immediate cause of death Cardio Vascular Renal Disease — Duration 7

Due to —

Due to

Other Conditions Epistaxis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

27. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. P. Hughes
Address 1443 Druid Hill Ave Date Dec 6 1948

X

I hereby certify that the above is a true and correct report of the death of the person named herein, to the best of my knowledge and belief. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

G69223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 54B

Registered No. G69223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Streets
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Wicomico Co.
(c) City or town Fruitland Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Luther Stephens

3 (b) If veteran, name war None
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Hortense J. - 1886
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) November 7 - 1886
8. AGE: Years 62 | Months — | Days 9 | If less than one day hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation Helper
11. Industry or business Log Lumber Mill

FATHER
12. Name Unknown
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Floyd Stephens
(b) Address Fruitland Wicomico Co. Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof Dec. 6 - 1948 (month) (day) (year)
(c) Cemetery or crematory Wicomico County Md
Location

18 (a) Funeral director Holloway & Co
(b) Address Salisbury Md.

19 (a) DEC 6 - 1948 (Date) received by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 1948, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Dec 5 1948.
and that I last saw him alive on Dec 5 1948

Immediate cause of death Respiratory Failure

Due to

Due to Post operative Craniotomy for malignant
Other Conditions Tumor of brain

(Include pregnancy within 3 months of death)

Date of operation 11/30/48

Major findings of operation: Malignancy of brain

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P.A. Peterson M. D.
Address University Hospital Date signed 12/6/49

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 153

069224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937 ✓

Registered No. 069224

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 Pitcher St
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 Pitcher St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Langford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mamie Langford
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Apr. 10, 1903

8. AGE: Years	Months	Days	If less than one day
45	7	22	hr. ..... min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Samuel Langford
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary White
15. Birthplace Balto Md

16 (a) Informant Beatrice Keys
(b) Address 625 Pitcher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co., Md

18 (a) Funeral director David L. Brown & Son
(b) Address 108 W Montgomery St

DEC 6 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 19 48, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 19 48, to Dec 2 19 48, and that I last saw him alive on Dec 2 19 48.

	Duration
Immediate cause of death Cardio Vascular Disease	1 yr.
Due to Cerebral Hemorrhage	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Williams Frey M. D.
Address 1938 Penna Ave Date signed 12/4/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

59425 BC-4P-23363 Registered 66[illegible]425

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st
(c) Hospital or institution: Provident Hospital 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 McKean Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Elroy Dilser

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/22/48

8. AGE: Years	Months	Days	If less than one day
		4 days	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation New born
11. Industry or business

FATHER
12. Name Carey Whitman Dilser
13. Birthplace Lancaster Co. Va

MOTHER
14. Maiden Name Doris Knox
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Doris Dilser
(b) Address 1607 McKean ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location
Returned by Hospital

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 1948, at 12 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1948, to 10-26 1948, and that I last saw him alive on 10-26 1948.

Immediate cause of death	Duration
Asphyxia	9 hrs.
Due to Ruptured Stomach	9 hrs.
Due to Shallow Respiration	9 hrs.
Due to Acute Abdominal Distension	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
Findings of autopsy: Diffuse Peritonitis - Ruptured Stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1033 Druid Hill Ave Date signed 10/26/48

VS 150

G69226

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G69226

Physicians: please write the causes of death clearly and legibly. Information must be complete and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto Genl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 40 W. West (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Willie Daniel
3 (b) If veteran, name war
3 (c) Social Security Account No. 246-10-5727

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Nov 24-1906
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1906

8. AGE: Years	Months	Days	If less than one day
42	-	10	hr. min.

9. Birthplace Wilson. N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Matt. Daniels
13. Birthplace N. C.

MOTHER
14. Maiden Name Fannie Mc. Gowan
15. Birthplace N. C.

16 (a) Informant James Daniels
(b) Address 40 W. West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 8-48 (month) (day) (year)
(c) Cemetery or crematory Wilson
Location N. C.

18 (a) Funeral director James Adams
(b) Address 142 W. Hill St

19 DEC 6 - 1948 Huntington Williams, M.D. (Registered by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1948, at 8 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6, 1948 to Dec. 4 1948 and that I last saw him alive on Dec 1, 1948.

Immediate cause of death Myocardial infarction — Duration 5 days.
Due to Coronary occlusion
Due to Arteriosclerosis
Other Conditions Mural thrombus of heart; Emboli to legs
(Include pregnancy within 3 months of death)
Date of operation Dec. 2, 1948
Major findings of operation: Emboli to Rt. femoral artery & thrombectomy
of autopsy Massive myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Marion C. Donaldson, Jr. M.D.
Address 1213 Light St Date signed 12/4/48

669227

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

669227 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Ensor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: THADDEUS A. LATHROUM

3 (b) If veteran, name war ——

3 (c) Social Security Account No. ——

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife Catherine E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 6, 1906

8. AGE: Years	Months	Days	If less than one day
42	7 10	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Jackson Transfer Co.

FATHER
12. Name Peter R. Lathroum
13. Birthplace Marylad

MOTHER
14. Maiden Name Agnes M. Kelly
15. Birthplace Maryland

16 (a) Informant Mrs. Catherine E. Lathroum
(b) Address 121 S. Poppleton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins Street

19 (a) DEC 6 - 1948 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1948, at 9:43 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary artery thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Apt M.D.
Medical Examiner.
Date signed 12-4-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 63228

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Please answer each question fully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 311 S. Mason Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 S Mason St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander H. Martell

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Widowed

6 (b) Name of husband or wife: Lina Adams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/18/86

8. AGE: Years	Months	Days	If less than one day
82	10	17	hr. min.

9. Birthplace Maryland (City, county, and state)
10. Usual Occupation Carpenter
11. Industry or business L. J.

FATHER
12. Name Jessie Martell
13. Birthplace Md

MOTHER
14. Maiden Name Mcknour
15. Birthplace

16 (a) Informant Harry Martell
(b) Address 311 S. Mason Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave
18 (a) Funeral director Lilly & Zilenziger
(b) Address 403 S. Mosher Street

19 DEC 6 - 1948 (Date rec'd by registrar) Transcription for Pollianna, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/1948, at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1948, to Dec 4 1948, and that I last saw h(M) alive on Dec 4 1948.

Immediate cause of death: Cerebral hemmorhage — Duration 1 day.
Due to: arteriosclerosis generalized
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Klumas M.D.
Address 2628 E. Monument St Date signed 12/7/48 M. D.

G69229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G69229

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Frederick Ave
(c) Hospital or institution: Colored Nursing Home
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 7 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 35 ?? old Frederick Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey H. Harvey

3 (b) If veteran, name war French and Ind. War | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Frances M. ~~Harvey~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1875

8. AGE: Years 73 | Months 5 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER — 12. Name Richard L. Harvey
13. Birthplace Va.

MOTHER — 14. Maiden Name Lee Perkins
15 Birthplace Va.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-48 (month) (day) (year)
(c) Cemetery or crematory National
Location Baltimore

18 (a) Funeral director George O. Talley
(b) Address 1600 Lanvale St. Baltimore, Md.

19 DEC 6 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1948, 2.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1948 to 12-4 1948 and that I last saw him alive on 12-3 1948.

Immediate cause of death Carcinomatosis General

Due to Carcinoma lung Left

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 months
2 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elliot W. Johnson M.D.
Address 2432 Frederick Ave Date signed 12/4/48

VS 150

X

Copy age is especially important. Physicians: please write the cause of death clearly and legibly

G69230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. G69230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be accurately supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1223 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Hanover St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Leona Hammel

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 216-09-2965

4. Sex: Fem.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry W. Hammel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1883

8. AGE: Years 65 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Ticket Clerk

11. Industry or business Motion Pic. Theatre

FATHER
12. Name James H. Reisinger
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma Barnard
15. Birthplace Baltimore Md.

16 (a) Informant Anna M. Reisinger
(b) Address 1223 Hanover St

17 (a) (Burial, cremation, or removal) (b) Date thereof 12/7/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Frederick Ave.

18 (a) Funeral director Fred. A. Kramer & Son
(b) Address 1414 S. Charles St. Baltimore, Md.

19 (a) DEC 6 - 1948 (Date received by registrar) (b) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4 1948 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8/1946 to 12/4 1948 and that I last saw h[illegible] alive on 12/3 1948.

Immediate cause of death: Carcinoma of liver — Duration: 2 yrs 9 mos

Due to —

Due to —

Other Conditions: none

(Include pregnancy within 3 months of death)

Date of operation 3/22/48

Major findings of operation: Carcinoma of Left lobe of liver. Complete obstruction of portal vein.

Date of autopsy (complete)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Lieber

Address 1226 Hanover St Date signed 12/6/48

VS 150

G69231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G69231

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 Webster st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 + 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 Webster St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethan V. Duncan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Jamesie E Duncan 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/27/1882

8. AGE: Years	Months	Days	If less than one day
66	7	16	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Finance Wife
11. Industry or business

FATHER
12. Name John Hammond
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida King
15. Birthplace Maryland

16 (a) Informant Mr. James Duncan
(b) Address 1403 Webster St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director J. J. Foley Sons
(b) Address 1918 Light St

19 (a) DEC 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1948, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1948 to Dec 3 1948.
and that I last saw deceased alive on Dec 3 1948

Immediate cause of death Cerebral Apoplexy.

	Duration
Due to	
Due to	
Other Conditions Arteriosclerosis Hypertension. Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Schwarck
Address 1337 S Charles St Date signed 12/3/48

VS 150

83a

G69232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Frisby (Travilah)
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 3016 Frisby (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry M. Bell

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-1342

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary C. Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23 1893

8. AGE: Years	Months	Days	If less than one day hr.	min.
55	6	13		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Driver
11. Industry or business Amer. Brewery

FATHER
12. Name Charles S. Bell
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret Patterson
15. Birthplace Ireland

16 (a) Informant Mrs. Bell
(b) Address 3016 Frisby St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 8, 1948 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 1830 East Biddle St

19 (a) DEC 6 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5- 1948 at 5 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6- 1942 to 12-5-1948 and that I last saw him alive on 12-5- 1948

Immediate cause of death	Duration
Myocardial Infarction (second attack)	12 hrs
Due to Cardio-vascular Disease	1942
Due to Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Milton C. Lang M. D.
Address 2117 Belair Rd Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Dr Lang: 10 yrs Medicine

X 12-6-48

69233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ Registered No. 69233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D. S. A.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Seneca Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH A. BARNHART (Elizabeth Barnhardt) DJM

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1865

8. AGE: Years	Months	Days	If less than one day
~~83~~ (DJM)	-	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Music Teacher
11. Industry or business

FATHER
12. Name William H. Barnhart
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth A. George
15. Birthplace Maryland

16 (a) Informant Mrs. Fannie P. Chambers
(b) Address 744 Rivard Blvd. Grosse Point Michigan
17 (a) Brial (Burial, cremation, or removal) (b) Date thereof 12-7-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (a) DEC 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4 1948, at 1:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Schmidt M.D.
Medical Examiner.
Date signed 12/5/48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 N. Milton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 N. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Janda

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jennie Janda
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) June 1881

8. AGE: Years	Months	Days	If less than one day
67	11	2	hr. min.

9. Birthplace Austria Hungary (Town, county, and state)
10. Usual Occupation Cabinet maker
11. Industry or business

MOTHER / FATHER
12. Name Frank Janda
13. Birthplace Austria Hungary

MOTHER
14. Maiden Name
15. Birthplace Austria

16 (a) Informant Jennie Janda
(b) Address 711 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-48 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Baltimore

18 (a) Funeral director Frank Gracchy Son
(b) Address 900 N. Chester St

19 (a) 12-6-1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1948, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary Thrombosis	12/3/48
Due to Cardio-Vascular disease	11/1/1946
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Pearce
Address 801 N. Kenwood Ave Date signed 12/5/48 M.D.

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G69235

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 ✓

Registered No. G69235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 203 S. Furrow Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 S. Furrow Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE CUSTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Laura Bishoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1868

8. AGE: Years	Months	Days	If less than one day
80	2	23	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Crystal Tavern

FATHER
12. Name Emanuel Custer
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia FRIEND
15. Birthplace Maryland

16 (a) Informant Mr. Ray C. Cole
(b) Address 203 S. Furrow St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/48 (month) (day) (year)
(c) Cemetery or crematory Bluemont Cemetery
Location Grafton, W. Va.

18 (a) Funeral director HARRY H. WITZKE
(b) Address 4101 Edmondson Ave.

12-6-1948 (Date rec'd by registrar) (b) Huntington-Williamson, W. Va.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1948, at 11:15 AM

21. I certify that I took charge of the remains described above, held an Inspection and Exa. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-6-48

X

G69236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G69236 Registered No.

Physicians: please write the causes of death clearly and legibly. Any false statement, omission or concealment of facts called for herein is punishable by fine and imprisonment. Be sure that the information you give is correct and complete.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution:
General German Aged Peoples Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

4

3 (a) FULL NAME Wilhelmina K. Rosendorn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1876

8. AGE: Years	Months	Days	If less than one day
72	1	25	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Franz Rosendorn
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Schultz
15. Birthplace Germany

16 (a) Informant Mr. J. George Walz, Secty.
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 E. Edmondson Ave.

19 (a) Dec 6 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5/48. 19 , at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3/48 to Dec. 5/48, and that I last saw her alive on Dec. 4/48.

Immediate cause of death — Duration

Coronary Thrombosis — 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Theodore Schmidt M. D.
Address 923 Hanover Date Dec 6 48.

VS 150

Tha G69237

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G69237
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-4
(e) Length of stay in Baltimore (yrs., mos., or days) 59 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4804 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3 (a) FULL NAME Catherine Strong
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1-1-89

8. AGE: Years	Months	Days	If less than one day
59	11	3	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Rapp
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Lehr
15. Birthplace Germany

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 8 '48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. & Longwood St
18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave
19 (a) DEC 9 1948 (Date rec'd by registrar) (b) Huntington Woods Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4- 1948, at 8:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12 1945 to 12-4 1948, and that I last saw her alive on 12-4 1948.

Immediate cause of death: Arteriosclerotic heart disease — Duration.....
Due to.....
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....
23. Signature John F. Wilmer, M.D.
Address Johns Hopkins Date signed 12/4/48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69238 ✓ G69238

LCH-124793

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1330 S. Charles Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY BALLARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/8/02

8. AGE: Years	Months	Days	If less than one day
46	2	28	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Nelson Ballard
13. Birthplace W. Va.

MOTHER
14. Maiden Name Betty Hanks
15. Birthplace W.Va.

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/6/48 (month) (day) (year)
(c) Cemetery or crematory Mason City
Location Mason City W. Virginia

18 (a) Funeral director Wm J Cook Inc
(b) Address 1217 St Paul St

19 (a) DEC 8 1948 (Date rec'd by registrar) (b) Registrar

V S 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6/48 19 , at 8:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23/48 19 to 12/6/48 19 , and that I last saw him alive on 12/6/48 19 .

Immediate cause of death	Duration
Uremia	Unk.
Due to Polycystic Kidneys	Life
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E Bechtold
Address Balto City Hosp. Date signed 12-6-48 M. D.

John E. Bechtold

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Be sure that every item is correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69239

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 131a

G69239 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 W. North Ave.,
(c) Hospital or institution:

15 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 W. North Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie A. Dischinger

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 213-05-5298

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife -------
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1895

8. AGE: Years	Months	Days	If less than one day
53	4	4 5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Buyer
11. Industry or business Schwartzman Dress Shop

FATHER
12. Name Pius Dischinger
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. Scheve
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Bertha M. Dischinger
(b) Address 2803 W. North Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.,

DEC 6 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1948 at 2.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Dec 5 1948 and that I last saw her alive on Dec. 5, 1948:

Immediate cause of death	Duration
Edema of Lungs	3 days
Due to Cardiac failure	1 wk.
Due to Chronic hypertension	4 yrs.
Other Conditions Ch. nephritis	4 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Geo E. Weller M. D.
Address 4100 Edmondson Ave Date signed 12/6/48

VS 150

93D

PLEASE WRITE PLAINLY with pen and ink. Use no abbreviations. Do not use ditto marks. Be sure to answer all questions, and make no unnecessary erasures. Please see that your certificate is complete and correct. Cause of death must be certified to the best knowledge and belief of the undersigned. Date of death must be entered on certificate before it will be registered. Underlining and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669240

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

669240 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 494 S. Brunswick St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 494 S. Brunswick St (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie E. Kirschke

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife August H.
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 9-16-1879

8. AGE: Years 69 | Months 2 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business At Home

FATHER
12. Name William Evans
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Hale
15. Birthplace Maryland

16 (a) Informant August H. Kirschke
(b) Address 494 S. Brunswick St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore. Md.

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Pl. 17.

19 (a) Dec 6 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4th 1948 at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19-43 19... to 12-4 19 48.
and that I last saw her alive on 12-6 19 48.

Immediate cause of death: Myocardial failure — Duration
Due to: Arteriosclerotic Heart disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry S. Lentz M. D.
Address 1709 Edmondson Date signed

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9241

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4813 Registered No. 9241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rural Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. 13 Box 74 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Mrs. Hilda Jones — Hilda May Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George L.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 22 1905

8. AGE: Years	Months	Days	If less than one day
43	1	12 / 2	hr. min.

9. Birthplace Smyrna Del. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Mulrooney
13. Birthplace Unknown

MOTHER
14. Maiden Name Carrie Foracre
15. Birthplace Delaware

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 8 1948 (month) (day) (year)
(c) Cemetery or crematory Gracelawn Cemetery
Location Wilmington Del.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) DEC 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5, 1948, at 5-19 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 22, 1948. to Dec 5, 1948. and that I last saw her alive on Dec 5, 1948.

Immediate cause of death: Hemorrhage of uterus — Duration

Due to Carcinoma of uterus with regional metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no about

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Hamm, M. D.
Address South Baltimore Gen Hosp Date signed Dec 5, 1948
Baltimore 30, Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 153

CERTIFICATE CORRECTED 3-8-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 69242

1248

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Casanova
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archie Lenox

3 (b) If veteran, name war

3 (c) Social Security Account No 226-28-5763

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Virginia.

6 (b) Name of husband or wife (Virginia) Lenox

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 11-10-05

8. AGE: Years	Months	Days	If less than one day
43	-	26	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name W. P. Lenox
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Heflin
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec 9 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Warrenton Va
Location

18 (a) Funeral director Wm. J. Thomas & Sons
(b) Address Church & Piedmont Sts.

19 (a) DEC 7 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1948, at 6 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3 1948 to 12-6 1948, and that I last saw him alive on 12-6 1948.

Immediate cause of death	Duration
Acute Hepatic Insufficiency	
Due to Biliary cirrhosis	
Due to Stricture of bile ducts.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Zinkham, M.D.
M. D.

Address Johns Hopkins Hosp. Date signed 12-7-48

VS 150

669243 ✓ 669243

LCH-121987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. _____

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3 (a) FULL NAME HENRY GARDNER

3 (b) If veteran, name war _____
3 (c) Social Security Account No. _____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Mary (d)
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 6/10/1889

8. AGE: Years	Months	Days	If less than one day
59	5	26	_____ hr. _____ min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Luther Gardner
13. Birthplace N.C.

MOTHER
14. Maiden Name Fannie Bowden
15. Birthplace N.C.

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. County
18 (a) Funeral director Mrs. Cobb, A. Elliott Dunphy
(b) Address 1129 N. Caroline St Baltimore, Md
19 (a) DEC 9 1948 (Date rec'd by registrar) (b) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6 1948, at 6:55 M
21. I certify that death occurred on the date above stated; that I attended deceased from 8/9/48 19__ to 12/6/48 19__, and that I last saw h im alive on 12/6/48 19__.

Immediate cause of death	Duration
METASTATIC CARCINOMA OF LIVER, SPLEEN, & LYMPH NODES	
Due to (PRIMARY SITE UNKNOWN)	6 MOS
Due to _____	
Other Conditions HYPERTENSIVE HEART DISEASE	

(Include pregnancy within 3 months of death)
Date of operation _____
Major findings of operation: SQ VARIOUS CELL CARCINOMA OF SUPRACLAVICULAR LYMPH NODE
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Thomas P. Jernigan M. D.
Address BALTIMORE CITY HOSP. Date signed 12-6-49

V S 150

Jernigan X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC-48-17172 104a G69244 Registered No. G69244

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hospital 3-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Rltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 S. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/9/45

8. AGE: Years	Months	Days	If less than one day
3 mo.			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 29 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948, at 11:40 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Upper respiratory infection

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature 11/15/48 George L. Merrill M.D.
Medical Examiner.
Title signed

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

59245

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 66[illegible]45

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Cheapside (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN MURPHY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School

18 (a) Funeral director
(b) Address

19 (a) DEC 7 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1948, at 9.25 A.M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner. M.D.

Date signed November 20, 1948

Commissioner of Health

Livingston Williams, M.D. Registrar

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669246

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx 6 days 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville, (If outside city or town limits, write RURAL and give town)
(d) Street No. 952 Frederick Road, (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James L. McKenzie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School NOV 29 1948

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 7 - 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1948, at 11:40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured pelvis
Fractured ribs
Due to Atelectasis of lung.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-3-48 at Approx. 7 P. M. 20/6
(b) Where did injury occur? In front of 2728 Wilkens Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by auto.

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 11-10-48

VS 151

correct age is especially important. Physicians: please write the cause of death clearly and legibly

69247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

69247 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 Hamplock Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine B Hickman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry A. Hickman

6 (c) If single, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20. 1888

8. AGE: Years 60 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jacob Graff
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Barbara Pfalmdt
15. Birthplace Balto. Md.

16 (a) Informant Mrs Loretta Landrock
(b) Address 4230 Hamplock Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-48 (month) (day) (year)
(c) Cemetery or crematory Edgewood Mem
Location Taylor Lane

18 (a) Funeral director John C. Melly Sons
(b) Address 2429 E. Oliver St

19 DEC 7 - 1948 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/48 19 , at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3/48 19 to 12/4/48 19 , and that I last saw her alive on 12/4/48 19 .

Immediate cause of death — Duration

Cerebro-vascular accident

Due to Hypertension

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lee N. Kastin M. D.
Address Sinai Hosp Date signed 12/4/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

(65)248 ✓ (65)248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave.
(c) Hospital or institution: Ba-Wil-Ba Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-2-48
(e) Length of stay in Baltimore (yrs., mos., or days) Unk.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County _____
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Brune St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3 (a) FULL NAME Leroy Manker

3 (b) If veteran, name war _____
3 (c) Social Security Account No. Unk.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C	Married

6 (b) Name of husband or wife Estelle Manker
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
47			hr. _____ min.

9. Birthplace Unk. (Town, county, and state)
10. Usual Occupation Unk.
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Williams
(b) Address 1317 Madison Ave.

17 (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (month) (day) (year)
(c) Cemetery or crematory _____
Location University Medical School NOV 29 1948

18 (a) Funeral director _____ Commissioner of Health
(b) Address _____

19 (a) DEC 7 - 1948 (Date rec'd by Registrar) (b) Lucretia Tor Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 11 - 1948 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1948 to 11/11 1948, and that I last saw h[illegible] alive on 11/11 1948.

Immediate cause of death	Duration
Chronic Cardio-vascular renal disease, a[illegible]	
Due to Uremia or Intoxication	
Probable Hypertension 1 yr	
Due to _____	
Other Conditions _____	

(Include pregnancy within 3 months of death)
Date of operation _____
Major findings of operation: _____
of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature H. A. Jackson M. D.
Address 600 N. Arlington Ave Date signed 11-11-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Any item not known or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

9249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 21B

Registered No. 69249

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution:
Univ Hos.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Clarksville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beulah Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife Ernest Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22 1923

8. AGE: Years	Months	Days	If less than one day
25	8	13	14 hr. min.

9. Birthplace Howard Co Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Frank Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Hewson
15. Birthplace Md.

16 (a) Informant Laura Smith
(b) Address Clarksville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-48 (month) (day) (year)
(c) Cemetery or crematory Hopkins Chapel
Location Highland Md

18 (a) Funeral director F.C. Higinbotham
(b) Address Ellicott City Md

19 DEC 7 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 1948, at 11:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1948, to DEC 5 1948, and that I last saw her alive on DEC 5 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Encephalitis probably tuberculous	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Nov 1, 48

Major findings of operation: Tuberculoma of pituitary gland

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. A. Peterson M. D.
Address Univ Hosp Date signed 12/7/48

X

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

LCH 101941 — Registered No. G64250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs. 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 East Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME LOUISE LOVEDAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/7/18 72

8. AGE: Years	Months	Days	If less than one day
76	10	27	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Loveday
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Hughes
15. Birthplace Maryland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 260 McCulloh St

19 (a) [illegible] (Date received by registrar) (b) Tuntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3/ 19 48. at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10/46 19 , to 12/3/48 19 , and that I last saw her alive on 12/3/48 19 .

Immediate cause of death Bronchopneumonia — Duration 3 days.
Due to
Due to
Other conditions Arteriosclerosis — Duration Chronic.
Cerebral Hemorrhage
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. Reichtold, M.D.
Address Balto City Hosp. Date signed 12-9-48

Please write plainly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

V S 154

107

69251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 69251 469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Balto
(c) City or town Catonsville 28
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 Oakdale Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD L. FREY, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-7749

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife RITA T. FREY (nee Tiemeyer)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1890

8. AGE: Years	Months	Days	If less than one day
58	5	15	hr. min.

9. Birthplace Balto Maryland (town, county, and state)

10. Usual Occupation Office Manager

11. Industry or business Addison & Clark Co.

FATHER
12. Name Benj. L. Frey
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella Popplein
15. Birthplace Maryland

16 (a) Informant MRS. RITA FREY
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/ 1948, at 10:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1948 to 12/4 1948 and that I last saw h alive on 12/4 1948

Immediate cause of death Ca of Head of Pancreas — Duration

Due to

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation Nov. 1948

Major findings of operation: Ca of Head of Pancreas.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Lemon M.D.
Address Mercy Hospital Date signed 12/6/48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

69252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

Registered No. 69252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnet Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WALTER P. MULLINEAUX

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Sarah E. Mullineaux
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1871

8. AGE: Years	Months	Days	If less than one day
77	2	7	hr. min.

9. Birthplace A. A. Co. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Continental Can Co.

FATHER
12. Name John Mullineaux
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Maranda Spears
15. Birthplace Md.

16 (a) Informant Mrs. Dorothy Lucas
(b) Address 2505 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 7 - 1948 (Date rec'd by registrar) (b) Euntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 19 48 at 4:05a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4/47 19 to 12/5-48 19, and that I last saw h alive on 12/4/48 19

Immediate cause of death	Duration
Myocardial Degeneration	3 yrs
Due to Senila	
Due to	
Other Conditions Chronic Nephritis	3 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. M. Harrington M. D.
Address 1710 E 33 St Date signed 12/6/48

correct age is especially important. Typewriter or print plainly in ink.

VS 150

93D

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 33

131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2075 Rockrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDITH JENNINGS HIGGINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 31, 1876

8. AGE: Years	Months	Days	If less than one day
72	10	5 6	hr. min.

9. Birthplace Boonsboro, Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name Henry B. Wilson
13. Birthplace Winchester, Va.

MOTHER
14. Maiden Name Ellen Kennedy
15. Birthplace Boonsboro, Md.

16 (a) Informant Mrs. Margaret W. Jackson
(b) Address 1221 Southview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/48 (month) (day) (year)
(c) Cemetery or crematory
Location Boonsboro, Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto. Md. Williams, Md

19 DEC 7 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1948, at 7:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948 to Dec 6 1948.
and that I last saw her alive on Dec. 5 1948

Immediate cause of death Chronic Nephritis - 12 mo. — Duration

Due to Gen. of Arterio-Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature Henry E. Wilson M. D.
Address 3 W. Biddle Date signed 12-6-48.

correct age is especially important. Physicians: please write the cause of death clearly. Use legal

VS 150

92:54 ES-123391

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

126

Registered No. 66925 4

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 EASTERN AVENUE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1867

8. AGE: Years	Months	Days	If less than one day
81	7	10	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Howard
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVENUE

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12-8-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Popular
Location Warren Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 DEC 7 1948 (Date rec'd by registrar) (b) Huntington Woodlawn, Md

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4- 1948, at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1948, to 12-4- 1948, and that I last saw h~~im~~ alive on 19

Duration
Immediate cause of death: Urinary Extravasation — 1 day
Due to:
Due to:
Other Conditions: Bronchopneumonia — 1 day

(Include pregnancy within 3 months of death)

Date of operation 12-3-48
Major findings of operation: above
of autopsy: None performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. A. Pritchard M.D.
Address 4940 Eastern Ave. Date signed 12-5-48

Please write plainly. Physicians: please write the causes of death clearly and legibly. Statements of cause of death are especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

LCH 124097

Registered No. 669255

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 18-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 W. Lombard Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GERHARDT LASPE

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 ? 1889

8. AGE: Years 59 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name August Laspe
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice ?
15. Birthplace Maryland

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 E. Fort Ave

19 DEC 7 - 1948 (Date rec'd by registrar) (b) Huntington Wilson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3/48 19 , at 2:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1948 to 12/3/ 1948, and that I last saw him alive on 12/3/48 19

Immediate cause of death BRONCHOPNEUMONIA — Duration 10 DAYS

Due to CEREBRAL THROMBOSIS — 2 MONTHS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jennings M. D.
Address BALTIMORE CITY HOSP. Date signed 12-7-48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Please state whether deaths were due to accident, suicide, or homicide. Please report occupation of every person 10 years old or over. Please see that age is correctly stated. Please see that birthplace is correctly stated. Please see that correct age is especially important.

V S 150

69256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 69256

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2525 Arunah Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 5
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2525 Arunah Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Stanley R. Jenkins

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Winifred N.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10th 1896

8. AGE: Years	Months	Days	If less than one day
52	1	26	hr. min.

9. Birthplace Fisher, Michigan (Town, county, and state)
10. Usual Occupation Assistant Agent
11. Industry or business P. D. C. Trust Co.

FATHER
12. Name August Jenkins
13. Birthplace Michigan

MOTHER
14. Maiden Name Agnes Pelletier
15. Birthplace Minnesota

16 (a) Informant Mrs. Winifred N. Jenkins
(b) Address 2525 Arunah Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) DEC 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6th 1948 at 7 40 A M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Inquiry find that said deceased came to his death on the day stated above.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R Davis M.D.
Medical Examiner
Date signed 1/16/48

12:57 ✓ 66:12:57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 20-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 McHenry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL J. McKEOWNE

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish-American	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Katherine G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1874

8. AGE: Years	Months	Days	If less than one day
73	11	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business Soldier

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Katherine G. McKeowne
(b) Address 2103 McHenry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cem.
Location 5501 Frederick Ave.

18 (a) Funeral director John J. Cowan & Son.
(b) Address 801-03 Hollins St.

19 (a) DEC 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1948, at 5:13 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to carbon monoxide

Due to

Other Conditions
Acute alcoholism.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 20/5-
(a) Date of injury December 6, 1948 at 4:07A M.
(b) Where did injury occur? 2103 McHenry St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No
(d) Means of injury Couch afire from lighted cigarette

23. Signature Medical Examiner. M.D.
Date signed 12/6/48

House not ofc

correct age is especially important. Physicians, please write the causes of death clearly.

669258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. 669258 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1361 Carey St
(c) Hospital or institution: 15-

(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1361 E. Carey St (If rural, give location) MD
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susannah Young

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	colored	Widowed

6 (b) Name of husband or wife Frank J. Young
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) Dec 25 1878

8. AGE: Years	Months	Days	If less than one day
69	11	6	11 hr. ____ min.

9. Birthplace Ellicott City Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name Tom Wilkins
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Mrs Mary L. Mason
(b) Address 1104 Riffs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 / 11 / 48 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Preastman St.

19 (a) DEC 7 - 1948 (Date rec'd by registrar) (b) Washington Boulevard, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5-1948, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948, to 12-5 1948, and that I last saw her alive on 12-4 1948.

Immediate cause of death: Myocarditis — Duration: 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Saunders
Address 1029 N. Stricker St Date signed 12-6-48

Please write clearly and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

B.C.-48-26209 — 69259 — 26011

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161a

Registered No. 69259

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16-2 DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Parrish St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jerome D. Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-26-1948

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name James Hill
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Lydia ?
15. Birthplace Baltimore, Maryland

16 (a) Informant James Hill
(b) Address 1003 N. Parrish Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Maryland

18 (a) Funeral director GEORGE G. KELSON
(b) Address 1303 Presstman Street

19 (a) DEC 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1948 at 9:30A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Atelectasis

Due to Distention of Intestines

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Frank L. Royster M.D.
Medical Examiner.

Date signed 12/5/48

correct age is especially important. Physicians: please write the cause in ordinary language.

VS 181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 69260

69260

correct age is especially important. Physicians: please write the cause of death very legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Bethel St P.O.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write R.F.D. and give town)
(d) Street No. 22 S. Bethel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WELDON SCOTT mp Weldon Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1892

8. AGE: Years	Months	Days	If less than one day
55 55	11	18	hr. min.

9. Birthplace Norfolk, Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Barbara Scott
(b) Address 22 S. Bethel Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 8, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Avenue

19 (a) DEC 7 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 1948 at 11 25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Pulaski M.D.
Medical Examiner.
Date signed 12/5/48

VS 151

69261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 69261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun
(c) Hospital or institution: Franklin Sq. Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 ARCADIA AVE (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME RINGGOLD, JAMES. HOWARD.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-7767

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife CARRIE RINGGOLD
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) JAN. 29. 1884.

8. AGE: Years 64 | Months 10 | Days 22 29 | If less than one day 12 hr. 10 min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation HARD WOOD FINISHER.

11. Industry or business

FATHER 12. Name JAMES P RINGGOLD.
13. Birthplace Md

MOTHER 14. Maiden Name MARY WHALAND.
15. Birthplace Md

16 (a) Informant Mrs. Carrie Ringgold
(b) Address 3711 Arcadia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Cockeysville, Maryland

18 (a) Funeral director Loring Bryant
(b) Address 5005 Park Heights Ave

19 (a) DEC 7 1948 (Registered by Registrar) (b) Washington Ave Baltimore, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 DEC 1948. at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3 1948. to 12-6 1948. and that I last saw him alive on 12-6 1948

Immediate cause of death MASSIVE PULMONARY EMBOLUS — Duration 3 days.

Due to THROMBOPHLEBITIS RT LEG.

Due to MYOCARDIAL INFARCTION

Other Conditions ARTERIOSCLEROTIC HEART DISEASE (Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo W. Baehr M. D.
Address Franklin Sq Hosp Date signed 12-6-48

BORKOVK.

Correct age is especially important. Physicians: please write the cause of death plainly, and do not use abbreviations or symbols.

VS 193

G69262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G69262

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Jenkins Convalescent Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH M. SCHNARR

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1863

8. AGE: Years	Months	Days	If less than one day
85	0	27	hr. min.

9. Birthplace Newark, N.J. (Town, county, and state)
10. Usual Occupation Business Manager
11. Industry or business Self

FATHER
12. Name Lorenzo Schnarr
13. Birthplace Germany

MOTHER
14. Maiden Name (Unknown) Kramer
15. Birthplace Germany

16 (a) Informant Vernon W. Eck, Sr.
(b) Address 3008 Kenyon Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/8/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Bloomfield, N.J.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 7 – 1948 (Date received by registrar) (b) Signature for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1948 at 11 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 – 1948 to Dec. 5 – 1948, and that I last saw him alive on Dec. 5 – 1948.

Immediate cause of death — Duration

R. H-D- Advanced

Due to

Due to

Other Conditions Chr. Bronch., adv. arteriosclerosis, adv

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Isaacs M. D.
Address 1700 Eutaw Pl Date signed 12-7-48

correct age is especially important. Physicians: please write the cause of death plainly.

VS 199

69263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 69263

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital ~~or institution~~ St. Joseph's 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 38 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 E. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ocie Sidney White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife King William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1890

8. AGE: Years	Months	Days	If less than one day
58	6	18	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard S. Baughan
13. Birthplace Virginia

MOTHER
14. Maiden Name Arigan Tyrie
15 Birthplace Virginia

16 (a) Informant King Wm. White
(b) Address 3504 E. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-48 (month) (day) (year)
(c) Cemetery or crematory Balto. Cemetery
Location North Ave. & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) DEC 7 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1948 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22, 1948, to Dec. 4, 1948, and that I last saw her alive on Dec. 4, 1948

Immediate cause of death Coronary Thrombosis — Duration
Due to Arterio-sclerotic Heart Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ray E. Persons Jr. M.D.
Address 4 S. Calvert St. Date signed 12/4/48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 159

X

669264

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 669264

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BON SECOURS HOSP. 9
(d) Length of stay in hospital or inst. (~~years, months~~, or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 GORSUCH AVE.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MR. JOSEPH EVERETT RUSSELL

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NO

4. Sex: MALE
5. Color or race: WHITE
6 (a) ~~Single, married, widowed~~ or ~~divorced~~

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 19 - 1883

8. AGE: Years 65 | Months 7 | Days 17 | If less than one day: hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation TOOL DRESSER
11. Industry or business CITY OF BALTIMORE

FATHER
12. Name WILLIAM R. RUSSELL
13. Birthplace MARYLAND

MOTHER
14. Maiden Name SELENA Mc DONALD
15 Birthplace MARYLAND

16 (a) Informant MRS. BLANCHE GREEN
(b) Address 813 GORSUCH AVE BALTO - MARYLAND

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 9 - 1948 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas. J. Evans & Son, Inc.
(b) Address 118 W. Mt. Royal Ave.

19 (a) DEC 7 - 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6/48 19 , at 930 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/30 1948, to 12/6 1948, and that I last saw him alive on 12/5 1948.

Immediate cause of death Cardiac Failure — **Duration**

Due to Coronary Occlusion
Bland-White-Garland block

Due to Arteriosclerotic C-V. Disease

Other Conditions
Cardiac pyelonephritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William S. Womack M. D.
Address BON SECOURS HOSP. Date signed 12/6/48

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G69265 20207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. G69265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE
(c) Hospital or institution:
BALTIMORE CITY HOSPITIALS
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County Baltimore
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 OVERBROOK RD.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN RECKENBERGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SEPARATED

6 (b) Name of husband or wife MARIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 18-1896

8. AGE: Years	Months	Days	If less than one day
52	7	18	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name JOHN RECKENBERGER (D)
13. Birthplace MD.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS BALTO CITY HOSPITALS
(b) Address 4940 EASTERN AVE

17 (a) Burial (b) Date thereof Dec. 8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Frederick Rd.

18 (a) Funeral director John L. Miller
(b) Address 2334 Jefferson St.

19 (a) DEC 7 - 1948 Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

P

20. DATE OF DEATH 12-5- 1948, at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5- 1948, to 12-5- 1948, and that I last saw him alive on 12-5- 1948.

Immediate cause of death Atelectasis L. Lung — Duration 1 day

Due to

Due to

Other Conditions Cirrhosis of liver

(Include pregnancy within 3 months of death)

Date of operation 8-15-48

Major findings of operation: Cirrhosis of liver

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C.A. Gitchford M.D.
Address 4940 Eastern Ave Date signed 12-6-48

V S 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

59266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 59266

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Hilken Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Eletta Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Blades

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F M	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/2/48

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Julius Blades
13. Birthplace Md.

MOTHER 14. Maiden Name Janet Blades
15. Birthplace Md McKenzie

16 (a) Informant Julius Blades
(b) Address 2206 Eletta Ave

17 (a) Burial (b) Date thereof Dec. 8, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem
Location Ritchie Highway

18 (a) Funeral director John F. Denny, Inc.
(b) Address 2008 Light St.

19 (a) DEC 7 1948 Huntington Williams, M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Dec 1948 at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Dec 1948 to 5 Dec 1948 and that I last saw h[illegible] alive on 5 Dec 1948

Immediate cause of death	Duration
Congenital Resp. Failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address St. Agnes Hosp. Date signed [illegible]

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669267 ✓ 669267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 43a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 Irving Place
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Irving Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ORLEN Sampson

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.	6 (b) Name of husband or wife	6 (c) If alive, give age
None	241-16-7150	M	W	Married	Addell	36 years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1898

8. AGE: Years	Months	Days	If less than one day
50	10	14	hr. min.

9. Birthplace Pembroke, N.C.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Will F. Sampson
13. Birthplace Pembroke N.C.

MOTHER
14. Maiden Name Callie Lowry
15. Birthplace Pembroke N. C

16 (a) Informant John Sampson
(b) Address 2315 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Sampson Cemetery
Location Deep Branch N.C.

18 (a) Funeral director THE DIPPEL BROTHERS
(b) Address 1800 E. Lombard St.

19 (a) DEC 7 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1948, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/7/48

VS 151

correct age is especially important. Physicians: please write the causes in plain English and

+

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 669608

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 48 Market Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Market Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES LEWIS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 30 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1948, at 12:25 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertrophy and dilatation of heart, Edema of brain and lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11-18-48

VS 151

correct age is especially important. Physicians: please give the cause of death clearly.

669-69

Died 12/3/48
DC - 66269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161C

Registered No. 669-69

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) 2d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 44 W Biddle St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Malcolm Thomas McGOOGAN III

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/30/48

8. AGE: Years	Months	Days	If less than one day
0	0	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name Malcolm T McGoogan
13. Birthplace Fitzgerald Georgia

MOTHER
14. Maiden Name Katherine Leigh
15. Birthplace Windfall N. Carolina

16 (a) Informant Dr. M. T. McGoogan
(b) Address 44 W Biddle St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 4 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 DEC 7 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Dec 1948 at 2.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Nov 1948 to 3 Dec 1948, and that I last saw him alive on 3 Dec 1948.

Immediate cause of death	Duration
Cerebral Anoxemia	
Due to Tracheobronchial obstruction	
Due to aspiration of vomitus	
Other Conditions Erythroblastosis fetalis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: (See above)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert K Schumacher M.D.
Address Md Gen Hosp Date signed 3 Dec

VS 180

114E

Please write plainly, with ink. Spell out full words. Be sure that every item is correct and complete. Age is especially important. Physicians: please write the causes of death clearly and legibly.

69270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. 69270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1154 Cleveland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 + 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1154 Cleveland St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anton Braecklein

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 217-07-4928

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude C. Braecklein

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) July 8, 1878

8. AGE: Years 70 | Months 4 | Days 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county and state)

10. Usual Occupation: Salesman

11. Industry or business: Retired

FATHER
12. Name: Ferdinand Braecklein
13. Birthplace: Germany

MOTHER
14. Maiden Name: Frey
15. Birthplace: Germany

16 (a) Informant: Gertrude C. Braecklein
(b) Address: 1154 Cleveland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-48 (month) (day) (year)
(c) Cemetery or crematory: Loraine Park
Location: Balto. County, Md.

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Avenue

19 (a) DEC 7 1948 (Filed by registrar) (b) Huntingtown, Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1948 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1948 to 12/6 1948 that I last saw her alive on 12/6 1948

Immediate cause of death: Carcinoma of oesophagus — Duration: 3 Mons.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D. M. D.

Address 2030 Wilkens Ave Date signed 12/7/48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 68 days
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Rockville (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 William St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Frank (Edwin) Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs. Frank E. Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9th, 1894

8. AGE: Years	Months	Days	If less than one day
54	9 mos	29	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Automobile Dealer

11. Industry or business

FATHER
12. Name Frank E. Williams
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Wallace
15. Birthplace Maryland

16 (a) Informant Mrs. Frank E. Williams
(b) Address 19 William St., Rockville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10 48 (month) (day) (year)

(c) Cemetery or crematory Rockville Cem.
Location Rockville Md.

18 (a) Funeral director Reuben (illegible)
(b) Address Bethesda Md.

19 DEC 8 - 1948 (Date rec'd by registrar) (b) Contington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7-48 19 , at 5.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2-48 19 to 12-7-48 , and that I last saw h/m alive on 12-7-48 19 .

Immediate cause of death Carcinoma of Rectum
Due to Metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-[illegible]-48

Major findings of operation: Generalized metastatic Carcinoma

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Montrose Lee Williams M. D.
Address Union Mem. Hosp. Date signed 12-9-48

VS 150

Correct age is especially important, physicians are urged to secure this information.

69272

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92B

Registered No. 69272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 W. Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 W. Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kemper Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George L. Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3 1864

8. AGE: Years	Months	Days	If less than one day
84	—	4	hr. min.

9. Birthplace Baltimore County Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Kember
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Barbara ?
15. Birthplace Germany

16 (a) Informant Mrs. Paul Bachmann
(b) Address 1304 W. Cold Spring Lane

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 12/10/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Gilbert & Son
(b) Address 1219 W. Fort Ave

19 (a) DEC 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1948, at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1948, to Dec 7 1948, and that I last saw her alive on Dec 6 1948.

Immediate cause of death	Duration
Mitral Insufficiency	6 years
Due to	
Due to	
Other Conditions General Arteriosclerosis Myocardial Failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. O. Bellman M.D.
Address 600 Baltimore Ave Towson Md
Date signed Dec 7 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BC-18-2636

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161a

Registered No. G69273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 N. Charles (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Baker (2nd twin) "B"

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	white	baby.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-3-48.

8. AGE: Years	Months	Days	If less than one day
—	—	1½	hr. min.

9. Birthplace Union Memorial (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ellis Thompson Baker III
13. Birthplace New Haven, Conn.

MOTHER 14. Maiden Name Margaret Ellen Dietz
15. Birthplace Detroit, Michigan

16 (a) Informant father
(b) Address same

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Permission for disposal
Location of Body given Union Memorial Hospital

18 (a) Funeral director
(b) Address

19 (a) DEC 8 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5-1948, at 1:39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3 1948 to 12-5 1948. and that I last saw him alive on 12-5 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paxton E. Clemens, M.D.
Address Union Memorial Date signed 12-5

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

Mail - 8800

BC- 48-2455

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. 66974

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27
(c) Hospital or institution: Womans Hospital, Balto. City, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 10 minutes

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto. 12, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5409 Spring Lake Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Stieff Twin
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-6-48

8. AGE: Years	Months	Days	If less than one day
0	0	0	0 hr. 10 min.

9. Birthplace Womans Hospital, Balto City, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Rodney Gilbert Stieff
13. Birthplace Balto. City, Md.

MOTHER
14. Maiden Name Dorothea Denison Stedman
15. Birthplace Hartford, Conn.

16 (a) Informant Dorothea Stedman Stieff
(b) Address 5409 Spring Lake Way

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Carnegie Lab

18 (a) Funeral director
(b) Address

DEC 8 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1948, at 1 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6, 1948, to Dec. 6, 1948, and that I last saw him alive on Dec. 6, 1948

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard A Stark M. D.
Address Womans Hosp Date signed 12/6/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lemb. & Queens Sts
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Mary's
(c) City or town Leonardtown, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kathleen Holt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/47

8. AGE: Years 1 Months 23 11 Days — If less than one day hr. min.

9. Birthplace Leonardtown, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Boyd Lon A. Brooks
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Holt
15. Birthplace ?

16 (a) Informant Mother
(b) Address Leonardtown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-48 (month) (day) (year)
(c) Cemetery or crematory St. Joseph Cem.
Location Morganza, St. Mary's Co., Md.

18 (a) Funeral director Pius B. Robinson
(b) Address Dameron, St. Mary's Co., Md.

19 (a) DEC 8 1948 (Date rec'd by registrar) (b) Cemetery or Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1948, at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1948 to 12/7 1948 and that I last saw her alive on 12/7 1948.

Immediate cause of death Septicemia

Due to Miliary TB

Due to TB Meningitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration: —; —; —; —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nicholas Mella M. D.
Address Univ. Hosp. Date signed 12/7/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. 66926

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before it is filed. Do not use abbreviations. If the exact date of birth is unknown, the age must be given. Underline the cause of death which is to be charged statistically. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. md.
(b) Street address 614 N. Bruce St
(c) Hospital or institution: 16 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 N. Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robt P. Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
67 yrs.	—	—	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Latner.
11. Industry or business

FATHER
12. Name Henry Robinson
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Lewis
15. Birthplace Va.

16 (a) Informant Adeline Robinson
(b) Address 644 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Lansdowne.

18 (a) Funeral director Metropolitan Funeral Home Inc
(b) Address 927 N. Mount St.

DEC 8 - 1948 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1948 at 9a. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1948 to Dec 5 1948, and that I last saw [illegible] alive on Dec 5 1948.

Immediate cause of death Congestive heart failure
Due to Hypertension Cardio-vascular disease
Due to
Other Conditions Eczema Chronic
(Include pregnancy within 3 months of death)

Duration: 4 mos

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Needle M.D.
Address 426 N. Gilmor Date signed 12/9/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC-48-2629 159 669277 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7.5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N. Chapel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl McKirt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-2-48

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph McKirt
13. Birthplace Md

MOTHER 14. Maiden Name Marie Alexander
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Pleasant View
Location

18 (a) Funeral director
(b) Address

19 (a) DEC 8 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1948, at 2 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2-1948 to 12-4-1948 and that I last saw h alive on 12-4-1948.

Immediate cause of death Prematurity	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Goldstein M. D.
Address J. Hopkins Hospital Date signed 12/7/48

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

278 H 24-2394 Hosp. Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 669278

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Enfield Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy McGohan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-5-48

8. AGE: Years	Months	Days	If less than one day
			19 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James C. McGohan
13. Birthplace

MOTHER
14. Maiden Name Thelma ?
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) DEC 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5- 1948, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5 1948 to 12-5- 1948, and that I last saw him alive on 12-5 1948.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Goldstein M. D.
Address J. Hopkins Hospital Date signed 12/7/48

VS 150

69279 ✓ 69279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: Hotel Joyce (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: FORD, William Joseph

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: 705-05-3695

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1897

8. AGE: Years	Months	Days	If less than one day
? 51			hr. min.

9. Birthplace: Frederick, Md. (Town, county, and state)
10. Usual Occupation: Railroad Engineer
11. Industry or business: B & O RR

FATHER
12. Name: John Ford
13. Birthplace: Frederick, Md.

MOTHER
14. Maiden Name: Anna Gompf
15. Birthplace: Harpers Ferry, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Nath. Cem.
Location: 550 E. Frederick Ave.

18 (a) Funeral director: John F. Cowan, Sons
(b) Address: 901-03 W. Hollins St.

19 (a) DEC 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION PM

20. DATE OF DEATH: Dec. 6 1948, at 4:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1948, to Dec. 6 1948, and that I last saw him alive on Dec. 6 1948.

Immediate cause of death: Hepatitis, acute with jaundice — Duration: Unknown
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

CERTIFICATION APPROVED BY
for Dr. Wm. Helfrich
CHIEF OR ASST. MEDICAL EXAMINER

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed: 12/7/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered; if none, so state. Be sure that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

9280

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51B ✓ Registered No. 6[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 5 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 20
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 5 N. Monroe St. (If rural give location)
(e) Citizen of foreign country?: (Yes or No) If yes, name country:

3 (a) FULL NAME: WILLIAM GODFRIED HENKEL, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife: Catherine Henkel (nee Scherer) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 16, 1866

8. AGE: Years	Months	Days	If less than one day
82	7	19	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Plumbing Business (self)

FATHER
12. Name: Godfried Henkel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary Mueller
15. Birthplace: Unknown

16 (a) Informant: Mrs. Lillian May Fleury
(b) Address: 5 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/48 (month) (day) (year)
(c) Cemetery or crematory: Western Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 8 - 1948 (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5, 1948 at 7:15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 10 '48 to Dec 3 '48, and that I last saw him alive on Dec 4 '48.

Immediate cause of death: Coronary Occlusion + Carcinoma the Lung — Duration: 2 days
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Allen C. Clauch M.D.
Address: 1 W. Mulberry Date signed: 12/16/48

correct age is especially important. Physicians: please write plainly.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

669~81
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 751 Dover Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 751 Dover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Kellam

3 (b) If veteran, give war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 1884

8. AGE: Years 64 | Months 9 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation H

11. Industry or business

FATHER
12. Name George Kellam
13. Birthplace Va

MOTHER
14. Maiden Name Cidie Dennis
15. Birthplace Va

16 (a) Informant Annie Wombtering
(b) Address 751 Dover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Baltimore Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1081 W Montgomery St

19 (Date rec'd by registrar) DEC 8 - 1948 Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6 1948, at 29, M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1948, to 12/6 1948, and that I last saw her alive on 12/5 1948.

Immediate cause of death Acute Lobar Pneumonia — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dan Drannelin M. D.
Address 1111 W Lee St Date signed 12/7/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

69282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 69282

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Stumps Alley
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Stumps al. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	married

6 (b) Name of husband or wife Ada White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1881

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace N.C (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James White
13. Birthplace N.C

MOTHER
14. Maiden Name Emma Jones
15. Birthplace N.C

16 (a) Informant Ada White
(b) Address 600 Stumps Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Baltimore Md

18 (a) Funeral director Sarah L Brown Son
(b) Address 108 W Montgomery St

19 (a) DEC 8 - 1948 (Date rec'd by registrar) (b) Burlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4 1948, at 46, M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/10 1948 to 12/4 1948, and that I last saw him alive on 12/4 1948.

Immediate cause of death Cerebral Hemmorhage

Duration 24 hrs.

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Trawler M. D.
Address 1111 W Lee St Date signed 12/7/48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

9283

ES-125075

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124B

Registered No. G69283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVENUE
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Myrtle Washington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April ? 1911

8. AGE: Years	Months	Days	If less than one day
37?	7		hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS-BALTIMORE CITY HOSPITALS
(b) Address 4940 EASTERN AVENUE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Laura A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) DEC 8 - 1948 (Date rec'd by registrar) (b) Huntingtown Williams Md

MEDICAL CERTIFICATION A

20. DATE OF DEATH 12-4- 1948, at 9:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4- 1948 to 12-4- 1948, and that I last saw her alive on 12-4- 1948.

Immediate cause of death Intracerebral & Subdural Hemorrhage (a)
Bronchopneumonia
Due to CERTIFICATION APPROVED BY for Chester J. Lubinski, M.D.
Due to by Assistant Medical Examiner, M.D.
Other Conditions Cirrhosis of liver
Pulmonary edema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Parsate M.D.
Address Baltimore City Hosp. Date signed 12/5/48

Please write plainly. Physicians: please write the causes of death clearly and legibly. Statement of age is especially important, correct age is

V S 150 TO BE APPROVED BY MEDICAL EXAMINER

83a

69284 V 471 G69284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 S DECKER AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 S DECKER. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN F. DRAGIER OR JOHN J. DRAIGER

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-6091

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED.

6 (b) Name of husband or wife STELLA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 13, 1892

8. AGE: Years	Months	Days	If less than one day
56	3	22	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation LABOR
11. Industry or business

FATHER
12. Name FRANK DRAGIER
13. Birthplace POLAND.

MOTHER
14. Maiden Name PAULINE ?
15. Birthplace POLAND.

16 (a) Informant STELLA. DRAGIER
(b) Address 1110 S DECKER AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 9, 48 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location GERMAN HILL RD.

18 (a) Funeral director THE DIPPEL BROS.
(b) Address 1800 E LOMBARD ST.

19 DEC 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 5 19 48, at 5 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18/48 19 to 12/5/48 19; and that I last saw him alive on 12/4/48 19.

Immediate cause of death: Ca of left lung — Duration 18 MO.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Esther F. Slenkovich M. D.
Address 1116 S. East Ave Date signed 12/7/48

correct age is especially important. If uncertain, please write the words "about" or "estimated."

VS 190

285 Bal 6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

471

Registered No. 669-285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2135 Cambridge St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Poland

3 (a) FULL NAME Bronislow Sierputowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-27-2974

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1891

8. AGE: Years 56 | Months | Days | If less than one day hr. min

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Pauline
15. Birthplace Poland ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Orazewski
(b) Address 1830 Eastern Ave
(c) Address Huntington Williams Mfg

DEC 8 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7-1948, at 4:10 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22-1948 to 12-7-1948, and that I last saw him alive on 12-7-1948.

Immediate cause of death: Respiratory failure — Duration

Due to: Carcinoma of lung with probable

Due to: cerebral metastases

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Ham W. Winternitz, M. D.
Address Johns Hopkins Hospital Date signed 12-7-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9286 ✓ 83a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6592-86

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MAGGIE Lee JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/1908

8. AGE: Years	Months	Days	If less than one day
40	9	23	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name Pearl Lane
15. Birthplace Balto. Md.

16 (a) Informant C. L. Davis
(b) Address 1301 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County

18 (a) Funeral director George G. KELSON
(b) Address 1303 Presstman St.

19 (a) DEC 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1948 19 48, at 9:00 AM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/7/48

VS 191

correct age is especially important. Typewriter, print with pen and ink. Physician: write the cause of death in lines 20 and 21.

669287
ES-102335

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVENUE
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 George St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flora Clinton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.	6 (b) Name of husband or wife	6 (c) If alive, give age
F	C	Married	Paul	years

7. Birth date of deceased (mo., day, yr.) June 22, 1910

8. AGE: Years	Months	Days	If less than one day
38	5	12	hr. min.

9. Birthplace Md
10. Usual Occupation
11. Industry or business

CERTIFICATION APPROVED BY
(Town, county, and state)
per: Emory H. Merrill M.D.
For: Dr. Wm. Helfrich
CHIEF OR ASST. MEDICAL EXAMINER.

FATHER
12. Name Emory (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Helen?
15. Birthplace Md.

16 (a) Informant RECORDS-BALTIMORE CITY HOSPITALS
(b) Address 4940 EASTERN AVENUE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 8 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St.

DEC (a) 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH 12-4- 1948, at 10:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1946 to 12-4- 1948, and that I last saw her alive on 12-4- 1948

Immediate cause of death	Duration
Anaphylactic reaction & shock with convulsions	5 min.
Due to Local subcutaneous infiltration 10 c.c. procaine 2%	5 min.
Due to	
Other Conditions Far advanced pulmonary tuberculosis. Hypertension. Kidney disease (Include pregnancy within 3 months of death)	2 yrs.

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12-4-48 10.20 A.M.
(c) Where did injury occur? Baltimore City Hospital (City or town) Baltimore (County) Maryland (State)
(d) Did injury occur about home, on farm, industrial place, in public place? hospital (Specify type of place) While at work? no
(e) Means of injury injection of procaine anesthesia.

23. Signature Margaret A. Morgan M. D.
Address Balt. City Hosp. Date signed 12-5-48

V S 150 TO BE APPROVED BY MEDICAL EXAMINER.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BCa 48-27002 6683-55

BALTIMORE CITY HEALTH DEPARTMENT ✓ 6F10284

CERTIFICATE OF DEATH 158

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Gilka

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Wh	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-7-48

8. AGE: Years	Months	Days	If less than one day
			2 hr. 30 min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name Leonard James Gilka
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name [redacted] Dorothy
15. Birthplace Balto. Md.

16 (a) Informant L. J. Gilka
(b) Address 562 Rolair Rd

17 (a) Burial (b) Date thereof 12/8/48
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd.

19 DEC 8 - 1948 (Signature) for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7- 1948, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1948 to 12-7 1948, and that I last saw him alive on 12-7 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral [redacted]	
Due to ?	
Other Conditions Pertilla	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence At M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [redacted] M.D.
Address [redacted] Date signed 12-7-48

Temple Baltimore, Md

VS 150

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Be sure to write correct age in each case where it is required. Be sure to write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. This certificate should be filled out completely and correctly. Physicians are requested to fill out the certificate of death clearly and legibly. Please write the causes of death clearly and legibly.

669-89 ✓ 669-89

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3005 Harview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Harview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Naughton (Norton)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 1895

8. AGE: Years	Months	Days	If less than one day
53	5	6	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Maintenance

11. Industry or business Baltimore City

FATHER
12. Name Patrick Naughton
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Thornton
15. Birthplace Ireland

16 (a) Informant: Miss Delia Naughton
(b) Address 3005 Harview Ave

17 (a) Burial (b) Date thereof 12- 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Leonard Neuby
(b) Address 2 E Madison St Baltimore, Md

19 (a) (Date received by registrar) (b) Registrar

DEC

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 1948 2:20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C B Tolbrook M.D.
Medical Examiner.
Date signed 12/5/48

X

G69290

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH

157E

G69290
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) all Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Turners Station
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Flemming Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Dowdy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-8-47

8. AGE: Years 1 | Months 19 7 | Days 28 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earl Dowdy
13. Birthplace Va.

MOTHER
14. Maiden Name Pearl Hines
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 11-48 (month) (day) (year)
(c) Cemetery or crematory Springfield Cem.
Location Suffolk Co. Va.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Blantyre Ave

19 (a) DEC 8 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1948, at 10 17 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5 1948, to 12-6 1948, and that I last saw her alive on 12-6 1948.

Immediate cause of death: Cardiac failure — Duration

Due to: Congenital heart disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature a. c. Lang M. D.
Address Johns Hopkins Hosp Date signed 12-7-48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

X

669-91 BALTIMORE CITY HEALTH DEPARTMENT 61 1684-91

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2602 Ulman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA WARSHAWSKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Mayer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 16, 1878

8. AGE: Years	Months	Days	If less than one day
70	8	22	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Abraham Green
13. Birthplace Russia

MOTHER
14. Maiden Name Annie ?
15. Birthplace Russia

16 (a) Informant Mrs Anna Levin
(b) Address 3618 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cemetery
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (b)
(Date rec'd by registrar) DEC 8 1948 Contington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8- 19 48, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8- 1948 to 12-8- 1948 and that I last saw h alive on 19

Immediate cause of death	Duration
Acute myocardial infarction	
Due to Hypertensive cardiovascular disease	
Due to Coronary sclerosis	
Other Conditions Diabetes mellitus	

(include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stefanie M. D.
Address Sinai Hosp. Date signed 12-8-48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 153

8 935

G69292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

G69292 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
2 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1742 Hanover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HILDEGARDE NORTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Clarence O. Norton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/23/1885

8. AGE: Years	Months	Days	If less than one day
63	3	13	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael J. Rowan
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth Thomas
15. Birthplace ?

16 (a) Informant Family
(b) Address 1742 S. Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn, Md.

18 (a) Funeral director James L. McCully
(b) Address 130 East Fort Ave.

DEC 8 1948
(Date rec'd by registrar) (b) Hunter Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1948, at 4:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral compression
Fractured R Parietal
Due to Fractured Rt Tibia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 12-2-48 at 11:45 P. 23/2 M.
(b) Where did injury occur? Heath & Hanover Street
(c) Did injury occur at home, on farm, industrial place, in public place? public What at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12-7-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69293 BALTIMORE CITY HEALTH DEPARTMENT G69293
CERTIFICATE OF DEATH 931 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 233 E. University Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 233 University Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daisy J. Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Married

6 (b) Name of husband or wife J. Henry Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 1880

8. AGE: Years	Months	Days	If less than one day
68	2	11	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Charles Doyle
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine Weaver
15. Birthplace Baltimore Md.

16 (a) Informant J. Henry Smith
(b) Address 233 E. University Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Flynn & Flemings
(b) Address 1426 Light St.

19 DEC 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1948 at 2.32 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1945 to 12-7 1948 and that I last saw h er alive on 12-7 1948.

Immediate cause of death Hypertensive Cardio Vascular Disease - Chronic myocarditis with myocardial degeneration — Duration several years.
Due to Acute Heart failure (Original) — 4 hrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Luther E. Leidle M. D.
Address 10 W. Madison St Date signed 12-8-48

VS 150

X

669294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 482

669294 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1270 Riverside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada Estelle Marsh.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James E. Marsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1880

8. AGE: Years	Months	Days	If less than one day
68	3	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Steven B. Hill
13. Birthplace Md.

MOTHER
14. Maiden Name Estelle Canon
15. Birthplace Baltimore, Md.

16 (a) Informant Carl Marsh (Son)
(b) Address 1270 Riverside Ave. 30

17 (a) Burial (b) Date thereof Dec. 9, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1420 Key Hy. Ave. 30

19 (a) DEC 8 - 1948 (b) Washington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6/48 19 , at 4:55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1948 to 12-6 1948.
and that I last saw her alive on 12-6 1948

Immediate cause of death: Carcinoma uteri & metastasis.
Due to
Due to
Other Conditions: Pathological fracture left femur
(Include pregnancy within 3 months of death)

Duration: 35 days.

Date of operation
Major findings of operation:
of autopsy: Absent.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles B. Macdonald M.D.
Address 1213 Light St. Date signed 12-6-48

Correct age is especially important if deceased was under one year or 100 years or more.

VS 150

X

G69295

BALTIMORE CITY HEALTH DEPARTMENT ✓ G69295
Registered No.

CERTIFICATE OF DEATH

186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Avenue
(c) Hospital or institution:
Ardleigh Nursing Home 13-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3536 Poole Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL MONROE RYAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-16-8195 A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Elizabeth Jane Ryan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 4, 1861

8. AGE: Years	Months	Days	If less than one day
87	10	2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Plasterer

11. Industry or business

FATHER
12. Name Samuel Ryan
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Keller
15. Birthplace Maryland

16 (a) Informant Mrs. Savilla G. Jackson
(b) Address 3536 Poole Street

17 (a) Burial (b) Date thereof Dec. 9, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's Hampden
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

DEC 8 - 1948
(Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6/48 19 , at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Fractured Hip

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing X cause of death, fill in the following: 13/8
(a) Date of injury 9/25/48 at 8:30 P.M.
(b) Where did injury occur? 3536 Poole Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Accidental Fell down flight of stairs inside

23. Signature John R Dawson M.D.
Medical Examiner.
Date signed 12/6/48

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correct age is especially important. Physicians: please write the causes of death legibly and clearly.

GC9C96

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 6854

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. # 7 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr. Mary Aloysia, (Bell) Boll

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29th, [illegible]

8. AGE: Years	Months	Days	If less than one day
82	9	8	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation Teacher.
11. Industry or business N. D. C.

FATHER
12. Name Mr. Boll
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Sr. MaryAsthus
(b) Address 7 Wm Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9th 48 (month) (day) (year)
(c) Cemetery or crematory Notch Cliff.
Location Glen Arm.

18 (a) Funeral director Geo. M. Fink Son.
(b) Address 811. W. Wolfe. St.

19 (a) Washington Williams, M.D. Registrar
DEC 8 1948 (Date rec'd by Local Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th 1948, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1948 to Dec 7th 1948, and that I last saw her alive on Dec 7th 1948.

Immediate cause of death	Duration
Acute Cardiac Dilatation	Past
Myocardial Insufficiency	2 years
Due to Arterio Sclerosis	long
Due to Hypertension	long
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. A. Schuland M. D.
Address 200 E. Cold. Pl. Date signed Dec 8/48

Add 2nd X

Physicians: please write the causes of death clearly and legibly. Accurate information and correct age is especially important.

G69697 BALTIMORE CITY HEALTH DEPARTMENT G69697

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cathedral & Madison Avenue (Knights of Columbus)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD F. CURTIS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Retired Salesman
11. Industry or business

FATHER
12. Name Richard F. Curtis
13. Birthplace Not obtainable

MOTHER
14. Maiden Name Margaret V. Perrin
15. Birthplace Not obtainable

16 (a) Informant W. L. Auer
(b) Address Gas & Electric Building

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. MEARS & SON
(b) Address 805 N. Calvert St.

19 DEC 8 - 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1948, at 10 A. M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-6-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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69698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 69698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 W. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OTTO J. (HELWIG) HELLWIG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Maude Libby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Property Mgr.
11. Industry or business Self

FATHER
12. Name Justus W. Hellwig
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Edler
15. Birthplace Germany

16 (a) Informant Risley Ensor
(b) Address 16 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 DEC 9 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1948, at 5 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH A.S.C.V.D.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12-7-48

correct age is especially important. Physicians: please write clearly in ink. Use one space between words. Do not abbreviate.

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NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

69299 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 669299

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3200 Bayonne Avenue
(c) Hospital or institution:
27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3200 Bayonne Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Hahn

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1873

8. AGE: Years	Months	Days	If less than one day
75	7	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business retired

FATHER
12. Name George Hahn
13. Birthplace Maryland

MOTHER
14. Maiden Name Lydia Smith
15. Birthplace Maryland

16 (a) Informant Mrs. Lillian Showell
(b) Address 3200 Bayonne Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/10/48 (month) (day) (year)
(c) Cemetery or crematory United Brethern
Location Brownsville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) DEC 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1948, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Dec 1948
and that I last saw her alive on Dec 6 1948

Immediate cause of death Congestive Cardiac failure

Due to Hypertensor cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M.D.
Address 5217 Harford Road Date signed 12-8-48

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669300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

139B

669300 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MERCY HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5210 Pembroke Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY MEAGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife MATHIAS MEAGER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 20, 1880

8. AGE: Years	Months	Days	If less than one day
68	10	16	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name JAMES FLINT
13. Birthplace W. VIRGINIA

MOTHER
14. Maiden Name MARY WISE
15. Birthplace MD.

16 (a) Informant (PATIENT)
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/10/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore MD

18 (a) Funeral director Wilhelm & Son
(b) Address 1219 E. Fayette St.

19 (a) DEC 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Dec 1948, at 11.58 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Dec 1948 to 6 Dec 1948, and that I last saw her alive on 6 Dec 1948.

Immediate cause of death CORONARY THROMBOSIS — Duration 3 DAYS

Due to ARTERIOSCLEROSIS

Due to

Other Conditions RELUC PERITONITIS

(Include pregnancy within 3 months of death)

Date of operation 2 Dec 48

Major findings of operation: PROLAPSED UTERUS

of autopsy: CORONARY THROMBOSIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Ferrie M. D.
Address Mercy Hospital Date signed 7 Dec 48

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69301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 69301

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3825 Beehler St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY H. GRIMES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/30/86

8. AGE: Years	Months	Days	If less than one day
62	8	7	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Metal Lather

11. Industry or business John Hampshire Co.

FATHER
12. Name Thomas Grimes
13. Birthplace Md.

MOTHER
14. Maiden Name Alice McKenzy
15. Birthplace Md.

16 (a) Informant Mrs. Mary Grimes
(b) Address 3825 Beehler Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/48 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Upper Darby Pa.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St

19 (a) DEC 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1948, at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrell M.D. Medical Examiner.
Date signed 12/7/48

669302 PINCUS SUTNIKOFF ✓ 669302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 So Pulaski St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 3
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 So Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pincus Sutnikoff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sonia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 68 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name not known
13. Birthplace Russia

MOTHER
14. Maiden Name not known
15. Birthplace Russia

16 (a) Informant Sonia Sutnikoff
(b) Address 405 So Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) DEC 9 1948 (Date rec'd by registrar) (b) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8-1948, at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1948 to 12/8 1948 and that I last saw h[illegible] alive on 12/8 1948.

Immediate cause of death	Duration
Cardiac Failure	
Due to arteriosclerosis	
Due to Cardio-vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. M. Freedman M. D.
Address 1111 St. Paul St Date signed 12/8/48

correct age is especially important. Physicians: please write plainly

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X

69303

- BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. 69303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2341 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN D. RAMEY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Emerson E. Ramey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1872

8. AGE: Years	Months	Days	If less than one day
76	1	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Michael Dougherty
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary A. Gilson
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Joseph Civis
(b) Address 3804 Beech Ave.

17 (a) Burial (b) Date thereof 12-9-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 (a) DEC 9 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1948, at 7.50p M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 3rd degree burns F02 Body 80

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 1/2
(a) Date of injury 12-6-48 at approx. 7.00 P. M.
(b) Where did injury occur? 2341 Eutaw Place
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Bed caught fire from lighted cigarette

23. Signature M.D.
Medical Examiner.
Date signed December 7, 1948

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 669304

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 E. University Parkway
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town 304 E. University Parkway
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia M. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John F. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1881

8. AGE: Years	Months	Days	If less than one day
67	2	9	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John C. Murray
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va.

16 (a) Informant W. Lawrence Miller
(b) Address 304 E. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/48 (month) (day) (year)
(c) Cemetery ~~xxxxxxxx~~ Lorraine
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

DEC 9 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1948, at 1104 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948 to Dec 8 1948.
and that I last saw h Sr alive on Dec 8 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 8 hrs.
Due to Arteriosclerosis — Unknown
Due to Senile —
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. R. Goldsborough M. D.
Address 2923 St. Paul St. Date signed

VS 130

Correct age is especially important. Physicians, please write and spell names plainly. Use ink.

669305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 Village Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Harvey E. Gilbert

3 (b) If veteran, name war: World War I.
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: May Gilbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 15, 1894

8. AGE: Years 54 | Months 4 | Days 23 | If less than one day: hr. min.

9. Birthplace Waltonville, Illinois (Town, county, and state)
10. Usual Occupation None - Disabled W.W.I Vet.
11. Industry or business

MOTHER / FATHER
12. Name R. H. Gilbert
13. Birthplace Illinois
14. Maiden Name Mary Lennington
15. Birthplace Illinois

16 (a) Informant Mrs. May B. Gilbert
(b) Address 19 Village Road, Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Ave.,
18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Baltimore
19 (a) DEC 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1948, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1948 to 12/7 1948. and that I last saw h alive on 12/7 1948.

Immediate cause of death	Duration
Cardio-respiratory arrest	1 min.
Due to Coronary Occlusion	12 days
Due to Coronary Sclerosis	
Other Conditions Bilateral Pneumonia; Total Blindness (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
Coronary occlusion; pneumonia; acute myocardial infarction
of autopsy

PHYSICIAN
Underline the cause to which death should be charged.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Md. Gen'l. Hosp. Date signed 12/9/48

94a

VS 153

669506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 669506

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 854 Carroll ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antone Schultz

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Catherine M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8 -1879

8. AGE: Years	Months	Days	If less than one day
69	-	-	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Swindell Bros

FATHER
12. Name John Schultz
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany.

16 (a) Informant Records B lto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Mem. Pk
Location Gorsuch Ritchie Hgwy

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 DEC 9 1948 (Date rec'd by registrar) (b) Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12- 8- 1948, at 1253 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8-48 1948, to 12-8 - 1948, and that I last saw him alive on 12-8- 1948

Immediate cause of death Carcinoma of Lung — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11. 30 48

Major findings of operation: Same

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.A. Pitchford M.D.
Address 4940 Eastern Ave Date signed 12-8-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

C.A. Pitchford

Elizabeth Schabdach.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 Registered No. G69307

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2927 W. Mosher St.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 W. Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH SCHABDACH

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Conrad Schabdach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1866

8. AGE: Years	Months	Days	If less than one day
82	5	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Christian Heerd
13. Birthplace Germany

MOTHER
14. Maiden Name Magdalena Scheel
15. Birthplace Germany

16 (a) Informant Miss Marie Schabdach
(b) Address 2927 W. Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 9 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7-48 19 , at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-45 19 , to 12-7-48 19 , and that I last saw h[illegible] alive on 12-7-48 19 .

Immediate cause of death ~~Asthma~~ Myocardial Failure — Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry S. Kimbel M. D.
Address 2703 Edmondson Date signed 12-7-48

VS 150

Harry S. Kimbel X

G69508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69508

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Parksley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Linder

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-3464 A

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret S. Linder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1 1877

8. AGE: Years 71 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Watchman

11. Industry or business Elliott Machine Co

FATHER
12. Name Henry Linder
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Annie Baus
15. Birthplace Baltimore Md

16 (a) Informant Margaret S. Linder
(b) Address 1001 Parksley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Harry A. Comacost
(b) Address 4204 Ridgewood Ave

19 DEC 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Dec. 1948, at 4:44 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to Arteriosclerotic Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer 2 M.D. Medical Examiner.
Date signed 8 Dec. 48

669309

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 669309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BON SECOURS HOSP 19
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 1½ hour
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 McHENRY ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MR. JOHN EDWARD HAUK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
Male	White	

6 (b) Name of husband or wife MRS. CARRIE HAUK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 15, 1873

8. AGE: Years	Months	Days	If less than one day
75	4	22	hr. min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)
10. Usual Occupation PAINTER
11. Industry or business

FATHER
12. Name — HAUK
13. Birthplace GERMANY

MOTHER
14. Maiden Name —
15 Birthplace —

16 (a) Informant MRS CARRIE M HAUK
(b) Address 1808 McHENRY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 10 '48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry H Wetzler
(b) Address 4101 EDMONDSON AVE

19 (a) DEC 9 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1948, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7 1948 to 12/7 1948, and that I last saw h~~im~~ alive on 12/7 1948.

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Occlusion (Dangl)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William S. Vonach M. D.
Address Bon Secours Hosp. Date signed 12/7/48

correct age is especially important. Physicians, please write plainly.

VS 150

X

69310

BC-48-2149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157H

Registered No. 69310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lauder Ave & Wabash St
(c) Hospital or institution: Maryland Chest Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Govans (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 Regester Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Sisson

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: M.
5. Color or race: Wh.
6 (a) Single, married, widowed, or divorced: Single.
6 (b) Name of husband or wife: None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): 12/7/48
8. AGE: Years — Months — Days — If less than one day: 2 hr. 25 min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name: George L. Sisson, Jr.
13. Birthplace: Kingsville, Md.

MOTHER
14. Maiden Name: Dorothy Mae Dourfler
15. Birthplace: Baltimore, Md.

16 (a) Informant: George L. Sisson Jr.
(b) Address: 809 Regester Ave. - Govans

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory: Prospect Hill Cem.
Location: Towson, Md.

18 (a) Funeral director: John Burns' Sons
(b) Address: Towson, Md.

19 (a) DEC 9 - 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1948, at 7:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1948, to Dec. 7 1948, and that I last saw h/M alive on Dec. 7 1948.

Immediate cause of death Congenital Polycystic

	Duration
Due to Kidneys, or Degeneration	
Due to of Kidneys.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. C. Fridley, M.D.
Address Md. Chest Hosp. Date signed 12/9/48

VS 150

69311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G69311

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 N. Spring St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME PERCY THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race NEGRO | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-1897

8. AGE: Years 51 | Months 52 | Days 11 | If less than one day 5 hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business Retired

FATHER 12. Name John E. Thomas

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Coca

15. Birthplace Md.

16 (a) Informant Mary Scott

(b) Address 209 Douglas Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.

Location A. G. County

18 (a) Funeral director Mrs. Ph. A. Ellerbe & Son

(b) Address 1320 N. Carolina St.

19 (a) DEC 9 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1948 at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1, 1948 to Dec. 6, 1948, and that I last saw him alive on Dec. 6, 1948.

Immediate cause of death Respiratory Failure — Duration

Due to Congestive Heart Failure

Due to Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congestive Heart Failure

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker M.D.

Address St. Joseph's Hospital Signed 12-7-48

VS 150

correct age is especially important. Please write plainly. Use ink. Do not use pencil.

669312 RAKES

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 669312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1324 N. Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 N. Calhoun Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Daniel Richard Rakes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Hester Rakes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20th, 1876

8. AGE: Years	Months	Days	If less than one day
72	9	17	hr. min.

9. Birthplace Trappe, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Peter Rakes
13. Birthplace Trappe, Maryland

MOTHER 14. Maiden Name Rebecca Bailey
15. Birthplace Trappe, Maryland

16 (a) Informant Hester Rakes
(b) Address 1324 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katye R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7th, 1948, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 1948 to 12-7 1948, and that I last saw h alive on 12-7 1948.

Immediate cause of death Cardio-Vascular Renal Disease — Duration 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Jackson M. D.
Address 606 N. Arlington Ave. Date signed 12-9-48

R. L. Jackson

PLEASE WRITE PLAINLY, with unfading ink. Fill in all blanks. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

669313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

669313 Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, and if a married woman, the name of her husband. Also the street address of residence and the correct age in years, months and days. In case deceased was a minor, the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 N. SHROEDER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1099 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Widow

6 (b) Name of husband or wife Annie Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1901

8. AGE: Years	Months	Days	If less than one day
47	8	7	hr. min.

9. Birthplace Effingham S. C.
(Town, county, and state)
10. Usual Occupation Storekeeper
11. Industry or business

FATHER
12. Name Webster Brown
13. Birthplace Effingham S. C.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Effingham S. C.

16 (a) Informant Estelle Woodley
(b) Address 1099 N. Schroeder St.

17 (a) Burial (b) Date thereof Dec. 11, 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 9 - 1948 (b) Katie R. Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 7, 1948 at 2.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 25 1948 to DEC. 7 1948 and that I last saw him alive on DEC. 6. 1948.

	Duration
Immediate cause of death CEREBRAL HEMORRHAGE	3 DAYS
Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address 1824 W. Franklin St Date signed 12-7-48

VS 180

G69314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G69314

Registered No. 3698

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 Madison ave
(c) Hospital or institution: Bar - Wd - Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lavinia Hawthorne

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	Widowed

6 (b) Name of husband or wife George Hawthorne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-1-1888

8. AGE: Years	Months	Days	If less than one day
60	4	6	hr. min.

9. Birthplace Petersburg Va (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business own home

FATHER
12. Name Allen Hardy
13. Birthplace Va

MOTHER
14. Maiden Name Lucinda Wilson
15. Birthplace Va

16 (a) Informant Mrs Estelle Seward
(b) Address 810 Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) DEC 9 - 1948 (Date rec'd by registrar) Courtesy of Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7-1948, at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7-1948 to 12-7-1948, and that I last saw her alive on 12-6-1948.

Immediate cause of death Cerebal hemorrhage — Duration 1 Month

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank H. Saunders M. D.
Address 1029 N. Stricker St Date signed 12-8-48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

X

69315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. G69315

LCH-12444

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 18-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 W. Lexington Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ETHEL CLEMONS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/10/98

8. AGE: Years	Months	Days	If less than one day
50	3	26	hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name May Kance
13. Birthplace ?

MOTHER
14. Maiden Name Amanda Waller
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) DEC 9 1948 (Date rec'd by registrar) (b) Registrar Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6/48 19 , at 1:20 P

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9/48 19 , to 12/6/48 19 , and that I last saw her alive on 12/6/48 19 .

Immediate cause of death Cardiac failure — Duration 2 mos.

Due to Hypertensive arteriosclerotic cardiovascular disease.

Due to

Other Conditions Bronchopneumonia Azotemia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David N. Marine M. D.
Address Balto City Hosps Date signed 12-7-48

David N. Marine X

V S 150

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G69316

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G69316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1530 Ralworth Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Ralworth Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM KELLER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	none	male	white	married

6 (b) Name of husband or wife Cora S. Deem
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) May. 30. 1879

8. AGE: Years	Months	Days	If less than one day
69	6	16	hr. min.

9. Birthplace Baltimore County (Town, county, and state)
10. Usual Occupation Baltimore Police Dept.
11. Industry or business Central Dist. Ret. 8 yrs

FATHER
12. Name August Keller
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mr. William E. Keller (Son)
(b) Address 1530 Ralworth Rd. -18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9. 1948 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk. Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address Baltimore Md.

19 (a) DEC 9 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6. 1948 at 1.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15/48 to 12/6-48.
and that I last saw ~~him~~ alive on 12-3-48.

Immediate cause of death	Duration
Coronary Embolism	3 mins
Due to Coronary Sclerosis	7 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. M. Herrman M. D.
Address 1710 E 33rd St Date signed 12/7/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

669317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. 669317

PLEASE WRITE PLAINLY, with pen and ink. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21e
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 7½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 S. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss MINNIE Schuman (MINNIE SCHUMAN)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1872

8. AGE: Years 76 | Months 6 mos | Days 20 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business At Home

FATHER
12. Name Frederick Schuman
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Schulte
15. Birthplace Germany

16 (a) Informant Miss Sophia Ahaus (niece)
(b) Address 805 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9. 1948 (month) (day) (year)
(c) Cemetery or crematory Louden Park Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (a) DEC 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 19 48 at 10⁵⁵ A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/30 19 48 to 12-6-19 48 and that I last saw her alive on 12-6 19 48.

Immediate cause of death
Carcinoma of
Due to ovaries with
Due to generalized
Carcinomatosis

Duration: 1 yr.

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: generalized Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury ANTHONY C. VERRONE

23. Signature Anthony C. Verrone M.D.

Address Maryland General Hosp. Date signed Dec 9, 1948

VS 150

9318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered (No.) 9318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home & Hospital
(c) Hospital or institution: CH & H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 13 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1764 E North Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Allen Revere (ALLEN LEE REVERE)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-12-4291

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Amelia

6 (c) If alive, age: 64 years

7. Birth date of deceased (mo., day, yr.) 11 - 27 85

8. AGE: Years 63 | Months 0 | Days 15 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business American Stores

FATHER
12. Name John Allen Revere
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Walker
15. Birthplace Va

16 (a) Informant Mrs. Amelia E. Revere
(b) Address 1764 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 10. 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (a) DEC 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 6 1948. at 5 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 5 1948. to 12 - 6 1948.
and that I last saw h alive on 12 - 6 1948.

Immediate cause of death: Cerebral Vascular Accident — Duration: 36 hr.
Due to: Hypertension
Due to: ASHD
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: Examination alone

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Gant M. D.
Address CH & H Date signed 12-6-48

Exact age is especially important. Physicians: please write the letters of each word clearly.

VS 150

69319

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 69319

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9-6
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 E. 30th Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME ALBERT WALTER ANDERSON

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 471-12-1752

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Ruby Anderson

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1893

8. AGE: Years 55 | Months 11 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace Minnesota (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Social Security

FATHER
12. Name Hans Anderson
13. Birthplace Denmark

MOTHER
14. Maiden Name Sophia Anderson
15. Birthplace Denmark

16 (a) Informant: Mrs. Anna R. Anderson
(b) Address 1809 E. 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-48 (month) (day) (year)
(c) Cemetery or crematory Owatonna
Location Owatonna, Minn.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

19 (a) Date received DEC 9 1948 (Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1948, at 12:45 M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While ..... work? .....
(d) Means of injury .....

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed 12-8-48

X

669520

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

669520 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 451 S Carrison 15
(c) Hospital or institution: Sinai Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 451 S Carrison (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Dunnock Bevan

3 (b) If veteran, name war none
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Richd A Bevan
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 13 1856

8. AGE: Years 92 | Months 2 | Days 24 25 | If less than one day hr. min.

9. Birthplace Port Deposit Md. (Town, county, and state)

10. Usual Occupation none
11. Industry or business none

FATHER 12. Name Wm. F. Johnson
13. Birthplace Unknown

MOTHER 14. Maiden Name Mary J. Adams
15. Birthplace Unknown

16 (a) Informant Mrs Frances Smith Daughter
(b) Address 114 W Lanvale St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12-10-48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Stewart & Morris Co.
(b) Address 108 W Franklin St.

19 DEC 9 - 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8/48 19 , at 9 A M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 12/8/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

669521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a

669521 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 N Stricker St. # 17
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Dade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29, 1908

8. AGE: Years	Months	Days	If less than one day
39	1	8	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Day worker

11. Industry or business Mo Coben

FATHER
12. Name Hyson Slater
13. Birthplace Md

MOTHER
14. Maiden Name
15. Birthplace Md

16 (a) Informant Annie Jennifer
(b) Address 1602 W Lilmor St

17 (a) Burial (b) Date thereof 12-10-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Hey. H. Kelson
(b) Address 1303 Freastman St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

DEC 9 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 19 48 at 7 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 19 48 to Dec 6 19 48, and that I last saw her alive on Dec 6 19 48.

Immediate cause of death: Sub-arachnoid hemorrhage — Duration

Due to Probable Congenital Aneurysm

Due to

Other Conditions Cachexia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Buchner M. D.
Address Mercy Hospital Date signed 12-6-48

X

669322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 22

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-
(c) Hospital or institution: WEST BALTO. GEN HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 BURGUNDY ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adam Capleski

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-03-9688

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife EMILY. CAPLESKI
6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) DEC 24 1891

8. AGE: Years	Months	Days	If less than one day
56	11	13	hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation BLACKSMITH.
11. Industry or business EASTERN STAINLESS STEEL Corp.

FATHER
12. Name ADAM CAPLESKI
13. Birthplace POLAND

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace NOT KNOWN

16 (a) Informant EMILY CAPLESKI
(b) Address 1106 BURGUNDY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC-11-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A. Co.

18 (a) Funeral director Bernard C Harley
(b) Address 121 E WEST ST

19 (a) DEC 9 1948 (Date received by registrar) (b) Huntingtown Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1948, at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1948 to Dec. 7 1948, and that I last saw h alive on Dec. 7 1948.

Immediate cause of death Shock, bronchial aspiration, following surgery for abdominal eviscerations

Due to Carcinoma of Rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec. 3, 48 Dec. 7, 48

Major findings of operation: Same

of autopsy:

Duration
1 year

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel L. Silverstein
Address Med Battle Ham Md. Date signed 12/8/48

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G693523 ES-110137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G693523

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVENUE
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 4
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Anne St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Briggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/14/21

8. AGE: Years	Months	Days	If less than one day
27	8	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Briggs
13. Birthplace Va.

MOTHER
14. Maiden Name Flossie Taylor
15. Birthplace Va.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVENUE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Brooklyn Md

18 (a) Funeral director Elroy S. Wilson
(b) Address 1000 Bentalou Ave

19 (a) DEC 9 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH 12-8- 1948, at 5:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1947 to 12-8- 1948, and that I last saw her alive on 12-8- 1948

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest L. Ellery, M. D.
Address Baltimore City Hosp. Date signed Dec 9

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

69524

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 669324

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address SINAI HOSPITAL
(c) Hospital or institution: 7.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 DA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 N CURLEY (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Margaret A. Wiseman

3 (b) If veteran, name war: No
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife CHARLES M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 4 1883

8. AGE: Years	Months	Days	If less than one day
65	9	4	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation
11. Industry or business AT HOME.

FATHER
12. Name DANIEL McENTEE
13. Birthplace IRELAND

MOTHER
14. Maiden Name MARY GRANT
15. Birthplace IRELAND.

16 (a) Informant MARGARET MIX
(b) Address 501 N CURLEY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 11 1948 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER.
Location 4200 BELAIR ROAD.

18 (a) Funeral director THE DIPPEL BROS
(b) Address 1600 E LOMBARD ST.

19 (a) DEC 9 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1948 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1948 to Dec 8 1948; and that I last saw h alive on Dec 8 1948.

Immediate cause of death Intracranial Hemorrhage. Cerebro vascular accident
Due to Left Hemiplegia. Stomach and Bleeding.
Due to Hypertensive Arteriosclerotic Heart Disease
Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: not done

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C M Stewart
Address SINAI Hospital Baltimore. Md. Date signed 12/8/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 189

X

Dr. White 669325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 669325 Registered No. 83B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Avenue
(c) Hospital or institution: Pinehurst Nursing Home 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Hamilton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marion E. Payne

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-1670

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 3, 1870

8. AGE: Years	Months	Days	If less than one day
78	1	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Levin L. Payne
13. Birthplace Md.

MOTHER
14. Maiden Name Sally Henderson
15. Birthplace Md.

16 (a) Informant Mrs. Mary M. Payne
(b) Address 2604 Hamilton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

DEC 9 - 1948 (Date rec'd by registrar) Hunting Town, Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6th 1948, at 11:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1948 to Dec 6 1948 and that I last saw h in alive on Dec 6 1948.

	Duration
Immediate cause of death: Broncho-pneumonia - Bilateral	Dec 3.
Due to: Cerebral Embolism with Mental retardation, no paralysis.	Stroke prior
Other Conditions: Intestinal hemorrhage 6 Dec 48	
Cause Indetermined. (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature James E White M. D.
Address 5214 Harford Rd Date signed 9 Dec 48.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 193

X

G693526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G693526

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5440 Belair Rd.
(c) Hospital or institution:
Gardenville Convalescent Home 27 → 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3812 Echodale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME H. MAURICE REINHART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mary E. Reinhart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28th, 1864

8. AGE: Years	Months	Days	If less than one day
84	1	10	hr. min.

9. Birthplace Frederick County, Md.
(Town, county, and state)
10. Usual Occupation Contractor & Builder
11. Industry or business

FATHER
12. Name Andrew Reinhart
13. Birthplace Frederick County, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace England

16 (a) Informant Mrs. J.W. Otto, Jr.
(b) Address 4 W. Elm Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/11/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore, Md.

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7801 Belair Rd.

19 (a) DEC 9 1948 (Date received by registrar) (b) Registrar

Lucille Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8th, 1948, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1946 to Dec. 8 1948 and that I last saw him alive on Dec 8 1948

Immediate cause of death	Duration
ARTERIOSCLEROTIC CARDIO-VASCULAR Disease	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J Himelfarb
Address 1801 EUTAW PL Date signed 12/9/48

Himelfarb

Please write plainly. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

669527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. 669527

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Belair
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rupert Francis Griffith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 15 1917

8. AGE: Years	Months	Days	If less than one day
31	4	18	hr. min.

9. Birthplace Belair, Harford, Maryland
(Town, county, and state)

10. Usual Occupation Grooms Race Horses

11. Industry or business

FATHER
12. Name Cleveland Griffith.
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Bertha Bull
15. Birthplace Harford Co. Md.

16 (a) Informant Mrs C Griffith
(b) Address Belair Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9 1948 (month) (day) (year)
(c) Cemetery or Crematory Rock Spring
Location Forest Hill Md

18 (a) Funeral director Chas E Cook
(b) Address Bel Air Md

19 DEC 9 - 1948 (Date rec'd by Registrar) (Signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1948, at 8:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1948 to Dec 6 1948 and that I last saw him alive on Dec 6 1948.

Immediate cause of death Myocardial failure — Duration

Due to Rheum. Heart D.?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. P. Benson, Jr. M. D.
Address Union Memorial Hosp. Date signed 12-6-48

VS 150

28

LCH - 58024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

Registered No. 669528

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 years and 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Strepper Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ANNABELLE LAKE LITCHKEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/7/01

8. AGE: Years	Months	Days	If less than one day
47	4	2	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herman Litchkey (d)
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Sarah Varlow (d)
15. Birthplace Maryland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Dec 13 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John E Moran
(b) Address 3000 E Baltimore St

19 (a) DEC 10 1948 (b) Lucinda for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/9/48 19 , at 8:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 19 40 to 12/9 1948, and that I last saw her alive on 12/9/48 19 .

Immediate cause of death	Duration
Spontaneous pneumothorax	
Respiratory insufficiency	2 mo.
Due to Far advanced bilateral	
Pulmonary tuberculosis	9 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maynard A. Magruder M. D.

Address City Hospital Date signed 12-9-48

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 669529

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6600 Beltona Ave
(c) Hospital or institution: Edgewood Nursing Home 9[illegible]3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Chestnut Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Caroline Bohnlofink

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband Henry Bohnlofink
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26th 1864

8. AGE: Years	Months	Days	If less than one day
79	8	12	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William Bechtold
13. Birthplace Md.

MOTHER
14. Maiden Name Christina
15. Birthplace Md.

16 (a) Informant Edward Bohnlofink
(b) Address 903 Chestnut Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 (a) DEC 10 1948 (Date rec'd by registrar) (b) Registered by Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8th 1948, at 11.30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1943 to Dec 8th 1948 and that I last saw h[illegible] alive on Dec 7th 1948.

Immediate cause of death: Chronic Myocarditis — Duration: 6 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury None

23. Signature R. R. Leady M.D.
Address 5706 Harford Rd Date signed 12-9-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 669530

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 826 E. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 E. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KATHERINE (KATIE) DORA SEAL

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Ulysses
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1871

8. AGE: Years	Months	Days	If less than one day
77	8	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Anthony Schafer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Clementine Johanning
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Lena Seal Poe
(b) Address 826 E. North Ave/

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul Street

19 (a) DEC 10 1948 (Date rec'd by registrar) (b) Venturo for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1948 19 , at 12 NOON M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1948 to Dec 7 1948 and that I last saw her alive on Dec. 6 1948

Immediate cause of death	Duration
Congestive Heart Failure	1 day
Due to Cardio-Vascular Hypertensive Disease	10 years ?
Due to Arteriosclerosis	10 years ?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael J. Dorsch M. D.
Address 1 W. Overlea Ave Date signed 12/9/48

VS 150

125108 BALTIMORE CITY HEALTH DEPARTMENT G69331

B.C.48-27179 CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE
(c) Hospital or institution:
BALTIMORECITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-HRS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 W. LEXINGTON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HUGHES BABY GIRL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 5 1948

8. AGE: Years	Months	Days	If less than one day
			7 hr. min.

9. Birthplace BALTIMORE MARYLAND
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name LEVY HUMPHREY
13. Birthplace NC.

MOTHER
14. Maiden Name MARY HUGHES
15. Birthplace MD.

16 (a) Informant RECORDS, BALTO. CITY HOSPITALS
(b) Address [illegible] EASTERN AVE. 9AM

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 12-8-48 (month) (day) (year)
(c) Cemetary or crematory B.C.H.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) DEC 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH 12-5- 1948, at 11.30M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5 1948 to 12-5- 1948 and that I last saw her alive on 12-5- 1948.

Immediate cause of death Prematurity — Duration 7hr. (Dec 5)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William P. Kean M. D.
Address Baltimore City Hosp. Date signed 12-7-48

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 669332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Paul & 23rd St.
(c) Hospital or institution:
Beck's Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4511 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS W. COLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	214-01-6926

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ethel L. Coler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1870

8. AGE: Years	Months	Days	If less than one day
78	3	15	hr. min.

9. Birthplace Champaign, Ill. (Town, county, and state)
10. Usual Occupation Credit Dept.
11. Industry or business Clothing Business

FATHER
12. Name William Coler
13. Birthplace U. S. A.

MOTHER
14. Maiden Name -- Seem
15. Birthplace Va.

16 (a) Informant Mrs. Ethel L. Coler
(b) Address 4511 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 10 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1948, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1948, to Dec 7 1948
and that I last saw h[illegible] alive on Dec 7 1948

Immediate cause of death Heart failure — Duration 6 hrs
Due to Acute (coron) Coronary Thrombosis — 6 hrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry T Beck M. D.
Address 100 E 23rd St Date signed 12/9/48

Correct age is especially important

VS 150

X

9333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 669333

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Conley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Ida A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1874

8. AGE: Years	Months	Days	If less than one day
74	4	27	hr. min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Butler
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Virginia Nixon
(b) Address 2222 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lenye A. Hoffland
(b) Address 1631 Druid Hill Ave

19 DEC 10 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6- 1948, at 2 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1948 to 12-6 1948, and that I last saw h alive on 19

Immediate cause of death Coronary thrombosis accident — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. E. Brady, Jr. M. D.
Address Provident Hospital Date signed 12-6-48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

n54 CORRECTED 1-11-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 669534

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1634 Druid Hill Ave.
(c) Hospital or institution:
Druid Laundry Bldg. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Druid Hill Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME TEACKLE (WALLACE) LANSEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Josephine Gaines
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1893

8. AGE: Years	Months	Days	If less than one day
55	10	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Businessman
11. Industry or business

FATHER
12. Name J. Edward Lansey
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Deborah Taylor
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Josephine G. Lansey
(b) Address 1701 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Baltimore County, Maryland

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 DEC 10 1948 (Date filed by Registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION p/

20. DATE OF DEATH December 8, 1948 at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-1- 1948 to Dec-8- 1948, and that I last saw h[illegible] alive on Dec-8- 1948.

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Jackson M.D.
Address [illegible] Date signed 12/10/48

VS 150

669535 BALTIMORE CITY HEALTH DEPARTMENT X ✓ 669535
CERTIFICATE OF DEATH 120 B
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catonsville Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 29 (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Oakley Village (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Dora Buchheister ✓

3 (b) If veteran, name war None
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed or divorced. Married
6 (b) Name of husband or wife John P. Buchheister
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 9-28-26
8. AGE: Years 22 | Months 2 | Days 11 | If less than one day hr. min.
9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Jeff Bridges
13. Birthplace Tenn
MOTHER 14. Maiden Name Cassie Waters
15. Birthplace Georgia
16 (a) Informant John Paul Buchheister
(b) Address 118 Oakley Village
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.
18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.
19 DEC 10 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1948, at 9:10 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 11-11 1948 to 12-9 1948, that I last saw her alive on 12-9 1948.

Immediate cause of death: Ulcerative Colitis — Duration 2 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Herbert J. Levidow
Address St. Agnes Hosp. Date signed 12/9/48 M.D.

correct age is especially important. Physicians, please write plainly.

VS 150

X

G69336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC-48-26809 157E

Registered No. G69336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 3/4hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Denison
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) December 9, 1948

8. AGE: Years	Months	Days	If less than one day
			7 hr. 45 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Owen Wesley King
13. Birthplace Easton, Md.

MOTHER
14. Maiden Name Muriel Elaine Ehrlich
15. Birthplace Baltimore, Md.

16 (a) Informant Owen W. King
(b) Address 123 N. Denison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director George L. Lohmeyer
(b) Address 2101 Eutaw Ave

19 DEC 1-0 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1948, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9, 1948 to Dec. 9, 1948, and that I last saw her alive on Dec. 9, 1948.

Immediate cause of death: Congenital anomaly - heart. — Duration: 1 day

Due to

Due to

Other Conditions: Possible atelectasis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Ehrlich M.D.
Address St. Joseph Hosp Date signed 12-10-48

VS 150

G69637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G69637

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1023 N Mount St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 N Mount St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Harrid

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	married

6 (b) Name of husband or wife Frank Harrid
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1898

8. AGE: Years	Months	Days	If less than one day
50	5	5	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John H. Morris
13. Birthplace Va.

MOTHER
14. Maiden Name Henrietta Taylor
15. Birthplace Va

16 (a) Informant Frank Harrid
(b) Address 1023 N Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave

19 DEC 10 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1948, at 4:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1948 to Dec. 8 1948 and that I last saw her alive on Dec 7 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Walter Shervington M. D.
Address 201 N Carey St Date signed 12/10/48

SHERVINGTON

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 3

669538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

102

Registered No. 669538

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1319 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE MILES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Frank Miles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1866

8. AGE: Years	Months	Days	If less than one day
82	6	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Hester Wilson
15. Birthplace Md.

16 (a) Informant M's Elizabeth Williams
(b) Address 1319 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) DEC 10 1948 (Date received by registrar) (b) Burington for Hillsinger Mortician

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Dec. 9, 1948, at 2:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1948 to Dec 9 1948; and that I last saw h[illegible] alive on Dec 7 1948.

Immediate cause of death	Duration
Hypertension	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Douglas Sheppard M. D.
Address 604 N Fulton Ave Date signed 12/10/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 153

669339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

669339 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 W. 34th St.
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Cecil Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALMA POISAL

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Charlton E. Poisal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1883

8. AGE: Years	Months	Days	If less than one day
65	6	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation nurse
11. Industry or business

FATHER
12. Name Franklin Upshur
13. Birthplace Snow Hill, Md.

MOTHER
14. Maiden Name Margaret Love
15. Birthplace Balto.

16 (a) Informant Miss L. Mai Poisal
(b) Address 2232 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 10 1948 (Date rec'd by registrar) Registration No. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1948, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Dec 8 1948. and that I last saw her alive on Dec 8 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 mos
Due to Arterio-Sclerosis, Hypertension	Gradual
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. K. Moody M. D.
Address 1403 Park Ave. Date signed Dec 9-'48

correct age is especially important. Physicians: please write the cause of death plainly.

VS 150

X

69340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 69340

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 S. Ellwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 S. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY ELIZABETH MILLER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John Miller
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 7, 1867
8. AGE: Years 81 | Months 4 | Days 2 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Adam Glock
13. Birthplace germany

MOTHER
14. Maiden Name Mary Voding
15. Birthplace germany

16 (a) Informant Mrs. Marie Voelker
(b) Address 700 S. Ellwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/48 (month) (day) (year)
(c) Cemetery or crematory First Evangelical
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Dec. 9, 1948, at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to Dec. 9 1948. and that I last saw h-er alive on Dec. 6 1948.

Immediate cause of death: myocardial failure — Duration: 2 wk.
Due to: senile arteriosclerosis, Glaucoma. — 6 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeDoux
Address 604 S. Ellwood Ave. Date signed 12/9/48 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

.41 C-41-26206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 665641

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as far as information is available. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & John St.
(c) Hospital or institution: Womans Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5409 Springlake Way (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Stieff - Twin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-6-48

8. AGE: Years	Months	Days	If less than one day
—	—	21	hr. min.

9. Birthplace Womans Hospital (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Rodney Gilbert Stieff
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Dorothea D. Stedman
15. Birthplace Hartford Conn

16 (a) Informant mother
(b) Address above

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Carnegie Sale

18 (a) Funeral director
(b) Address

19 DEC 10 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7-48 19 , at 12 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6- 1948 to 12-7 1948 and that I last saw h. alive on 12-7-48 19

Immediate cause of death	Duration
Anoxia	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard L. Bland M. D.
Address Womans Hosp. Date signed 12/9/48

VS 180

G69342

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G69342

CERTIFICATE OF DEATH 157M

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Druid Hill Park Ave. at 41st St.
(c) Hospital or institution: Childrens Hospital School
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State District of Columbia (b) County U.S.A.
(c) City or town Washington, D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Varnum St., N.W.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME PATRICIA ANN O'CONNOR

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 | 28 | 1941

8. AGE: Years	Months	Days	If less than one day
7	8	11	hr. min.

9. Birthplace Washington D.C. (town, county, and state)
10. Usual Occupation Student
11. Industry or business —

FATHER
12. Name DANIEL O'CONNOR
13. Birthplace TEXAS

MOTHER
14. Maiden Name ELIZABETH L. KILLEEN
15. Birthplace ATLANTIC CITY, N.J.

16 (a) Informant FATHER
(b) Address 131 VARNUM St. N.W. D.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/10/48 (month) (day) (year)
(c) Cemetery or crematory —
Location Washington, D.C.

18 (a) Funeral director Frank Gallina
(b) Address 3821-14th St. N.W.

19 DEC 11 1948 Registrar Wm. H. Wheeler M.D.
Washington, D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1948, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1948 to 12-10 1948 and that I last saw HER alive on 12-10 1948.

Immediate cause of death	Duration
CARDIAC FAILURE	minutes
Due to PULMONARY EMBOLISM	minutes
Due to OPERATION 12-10-48 for reduction of congenital dislocation Lt. Hip	2½ hrs
Other Conditions multiple congenital abnormalities (Include pregnancy within 3 months of death)	Post op.

Date of operation 11-17-48 & 12-10-48
Major findings of operation: Posterior type congenital dislocation Lt. Hip
Autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature O. D. Ehrisman M.D. for Dr. E. E. Bennett M. D.
Address Childrens Hosp. School Date signed 12-10-48

VS 3

69343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162 B

Registered No. 69343

PLEASE WRITE PLAINLY, with unfading ink. Do not use abbreviations. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3533 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3533 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin Solon Arnold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1868

8. AGE: Years	Months	Days	If less than one day
80	2	11	hr. min.

9. Birthplace Anne Arundel County, Maryland
(Town, county, and state)

10. Usual Occupation Sign Painter

11. Industry or business self

FATHER
12. Name Thomas E. Arnold
13. Birthplace A. A. Co. Maryland

MOTHER
14. Maiden Name Eugenia Newburn
15. Birthplace A. A. Co. Maryland

16 (a) Informant Clarence I. Arnold
(b) Address 3533 Reisterstown Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/11/48 (month) (day) (year)
(c) Cemetery or crematory Waugh Chapel
Location Odenton, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) DEC 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1948, at 5:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1948 to Dec. 9 1948 and that I last saw h[illegible] alive on Dec. 9, 1948.

Immediate cause of death

Senility — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest Lewis, M.D.

Address 1605 N. Broadway Date signed 12/10/48

VS 150

G69344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G69344

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1040 W. Barre St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1040 W. Barre St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah E. Kelley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Geo. F. Deitzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26th 1872

8. AGE: Years	Months	Days	If less than one day
56	2	13	hr. min.

9. Birthplace Cumberland Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Andrew Kelley
13. Birthplace Pa.

MOTHER
14. Maiden Name Jane Kaufman
15. Birthplace W. Va.

16 (a) Informant John Deitzel
(b) Address 5637 Oregon Ave

17 (a) Burial (b) Date thereof 12/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey, Md.

18 (a) Funeral director William Cook Inc.
(b) Address DEC 11 1948 St. Paul St.

19 (a) (Date rec'd by registrar) Registrar for Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9th 1948, at 11a. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1948 to Dec 9 1948 and that I last saw h[illegible] alive on May 9 1948.

Immediate cause of death Carcinoma of Uterus — Duration 7 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry F. Kates
Address 517 Scott St. Date signed 12/10/48 M.D.

PLEASE WRITE PLAINLY with unfading ink. Do not use pencil. Do not fold. Do not roll. Use typewriter if possible. Be sure to answer every question. Do not leave any blanks. If none, write none, or insert 0 (cipher). Please see that your answers are full and complete and that your handwriting is legible. Be sure to give the exact place of death and the full name and address of informant. Please see that the date of death is correctly stated. Be sure to give the cause of death so that a definite and unmistakable statement is made. Do not use indefinite or unsatisfactory terms. Do not report symptoms instead of disease. Do not report mode of dying instead of cause of death. Do not report conditions resulting from disease instead of disease. Do not report disease of subordinate importance instead of principal disease. Do not report contributory disease instead of principal disease. Be sure to report the principal cause of death. Be sure to report the cause of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

Harry F. Kates

9345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 163B

Registered No. G69345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALFRED LOWE

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-3993

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	divorced

6 (b) Name of husband or wife Jane T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1896

8. AGE: Years	Months	Days	If less than one day
52	9	4	hr. min.

9. Birthplace Eldorado, Iowa
(Town, county, and state)
10. Usual Occupation Traffic Manager
11. Industry or business Fred Weiss

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Jane T. Lowe
(b) Address Bethlehem, Pennsylvania

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-48 (month) (day) (year)
(c) Cemetery or crematory National
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1219 St. Paul St.

19 (a) DEC 11 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1948, at 8.30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Barbiturate Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-4-48? at ? M.
(b) Where did injury occur? 606 St. Paul Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury ingestion of sleeping tablets

23. Signature Paul L. Reyburn M.D.
Medical Examiner
Date signed December 7, 1948

VS 151

correct age is especially important. Physicians: please write the causes of death clearly.

69346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

Registered No. G69346

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga

(c) Hospital or institution: Mercy Hospital Inst.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d.

(e) Length of stay in Baltimore (yrs., mos., or days) 36yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1113 Harlem Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME BEATRICE ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Charles Robinson 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22/1906

8. AGE: Years 42 | Months 10 | Days 20 | If less than one day hr. min. 12

9. Birthplace Massachusetts (Town, county, and state)

10. Usual Occupation Home Maid

11. Industry or business

FATHER

12. Name Oscar Hill

13. Birthplace South Carolina

MOTHER

14. Maiden Name Martha Moss

15. Birthplace Virginia

16 (a) Informant Charles Robinson

(b) Address 1113 Harlem ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto Md

18 (a) Funeral director George S. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) DEC 11 1948 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9/48 19 , at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1948 to Dec 9 1948, and that I last saw her alive on Dec 9 1948

Immediate cause of death Acute cardiac failure

Due to Rheumatic heart disease, chronic

Due to

Other Conditions Rupt Tubo-ovarian Abscess with Peritonitis Septicemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 12-10-48

Duration: ? years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph L. Aponte

Address Mercy Hosp Date signed 12/10/48

Aponte x

correct age is especially important. Typewriter process or black ink.

VS 150

669347

GM. 124880

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G69347

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Mosher ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jerome Minor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19- 1890

8. AGE: Years	Months	Days	If less than one day
58	4	22	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jerry Minor
13. Birthplace MD.

MOTHER
14. Maiden Name Frances Short
15. Birthplace MD.

16 (a) Informant Records Balto. City hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart cem.
Location Charles Co. Md.

18 (a) Funeral director George G. Nelson
(b) Address 1303 Eastern ST

19 (a) DEC 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12- 10- 1948, at 12.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26- 1948, to 12-10- 1948 and that I last saw him alive on 12- 10 -1948.

Immediate cause of death: C.V.D. Left sided Hemiplegia
Due to: Par. Stroke, due to Intrinsic Thrombosis
Due to: Hypertension
Other Conditions:
(Include pregnancy within 3 months of death)

Duration
N.S.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. F. Nelson
Address BCH
Date signed 12-10-48 M. D.

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 669348

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3804 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvan Eckhaus

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-16 6486

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ruth Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 10 1897

8. AGE: Years	Months	Days	If less than one day
51	2	29	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business City

FATHER
12. Name Sigmund Eckhaus
13. Birthplace Germany

MOTHER
14. Maiden Name Carrie Reinach
15. Birthplace Virginia

16 (a) Informant Ruth Eckhaus
(b) Address 3804 Park Heights Ave.

17 (a) Burial (b) Date thereof 12-12-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom Cong.
Location O, Donnell Street

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Avenue

19 (a) DEC 11 1948 (b)
(Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1948 at 2-10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948 to Dec. 9 1948, and that I last saw him alive on Dec. 7 1948.

	Duration
Immediate cause of death Coronary Insufficiency	3 mos
Due to Arteriosclerotic Ht. Dis	?? yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence Dec. 9, 1948 at 1.45 A.M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Conrad & Cohen M. D.
Address 5901 Park Heights Ave Date signed 12/9/48

correct age is especially important. Physicians: please write the number of years in each agency.

VS 150

69349 B.C.H.-26676

BALTIMORE CITY HEALTH DEPARTMENT ✓ G69349 Registered No.

CERTIFICATE OF DEATH 123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Centre
(c) Hospital or institution: Mercy Hosp 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Green (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joanne Ferrari

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30 1948

8. AGE: Years	Months	Days	If less than one day
		11 10	hr. min.

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Ferrari
13. Birthplace Balto

MOTHER
14. Maiden Name Santina Cascio
15. Birthplace Balto

16 (a) Informant Louis Ferrari
(b) Address 408 N Green St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md Grandview Dellabrook

18 (a) Funeral director Frank Della Rocca
(b) Address 322 S. High St

19 DEC 11 1948 (Registered by Registrar) (By) Courtney for Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1948 at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3 1948 to 12-10 1948
and that I last saw h i alive on 12-10 1948

Immediate cause of death
Peritonitis
Due to Congenital stricture of rectum + rupture of rectum
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 12-8-48
Major findings of operation: Stricture of rectum - opened
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos Cascy Jr. M. D.
Address Mercy Date signed 12-10-48

X

VS 150

Correct age is especially important. Any error should be reported promptly to the Registrar.

9350

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G69350

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4206 GRACE COURT
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 GRACE COURT
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH MARY MALLONEE

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife ELWOOD MARTIN
6 (c) If alive, give age 0 years

7. Birth date of deceased (mo., day, yr.) MARCH 25, 1894

8. AGE: Years	Months	Days	If less than one day
54	8	16	hr. min.

9. Birthplace CZECHOSLOVAKIA
(Town, county, and state)

10. Usual Occupation
11. Industry or business U.S. INDUSTRIAL ALCOHOL

FATHER
12. Name CHARLES RYS
13. Birthplace CZECHOSLOVAKIA

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace CZECHOSLOVAKIA

16 (a) Informant MRS. MARIE LEIMBACH
(b) Address 4206 GRACE CT.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/13/48 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST - 30

19 (a) DEC 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 10, 1948, at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to Dec 10 1948 and that I last saw her alive on 12/9 1948

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 203 Tulane Date signed

correct age is especially important. Physicians, please write plainly.

VS 150

83a

2324 Reisterstown Rd.

G69351

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G69351

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution:
Twilight Nursing Home 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 145 N Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Cumor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23 1879

8. AGE: Years	Months	Days	If less than one day
69	4	17	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name John Cumor
13. Birthplace unknown

MOTHER
14. Maiden Name
15. Birthplace unknown

16 (a) Informant Edgar Cumor
(b) Address 3025 Elm Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-48 (month) (day) (year)
(c) Cemetery or crematory Mt Wariah Memorial
Location Baltimore

18 (a) Funeral director Frank H Seyfu
(b) Address 814 N. Eutaw St.

19 (a) DEC 11 1948 (Date rec'd by registrar) (b) Huntington Wilkins Burial Permit

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1948, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1948 to Dec 9 1948, and that I last saw h. alive on Nov 26 1948.

Immediate cause of death (a)	Duration
Chronic hypocondritis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. H. Cutterman M. D.
Address 2324 Reisterstown Rd Date signed 12/10/48

VS 150

X

G69352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G69352

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 51
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Comet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HOWARD HARRINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1892

8. AGE: Years	Months	Days	If less than one day
56	4	4	hr. min.

9. Birthplace Atlanta, Georgia
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Camp Holibird

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Minnie Harggins
(b) Address 1125 Comet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Balto, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 (a) DEC 11 1948 (Date rec'd by registrar) (b) Huntington Williams Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1948, at 3:05PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Ryon M.D.
Medical Examiner
Date signed 12-6-48

VS 181

G69353

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 B

Registered No. G69353

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 31
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 Lloyd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLY MAY (DOWNEY) DOWNDY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife John Downdy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1916

8. AGE: Years	Months	Days	If less than one day
32	4	29	hr. min.

9. Birthplace Henderson, North Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hamp Jones
13. Birthplace Henderson, N.C.

MOTHER
14. Maiden Name Ida Lewis
15. Birthplace Henderson, N.C.

16 (a) Informant: Willie Mae Scott
(b) Address 1416 E. Madison St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 12/11/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Cal. Cem.
Location Brooklyn

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Avenue

19 DEC 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1948, at 9:48 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Adneo-Sarcoma of the stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 12/8/48

VS 181

X

669354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 669354

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Road
(c) Hospital or institution:
Anderson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walburga Niederhoefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John Niederhoefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28 1871

8. AGE: Years	Months	Days	If less than one day
77	1	12	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Fridolin Staub
13. Birthplace Germany

MOTHER
14. Maiden Name Franciska Krumm
15. Birthplace Germany

16 (a) Informant Pauline Niederhoefer
(b) Address 4203 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry H. Thomas
(b) Address 4204 Ridgewood Ave

19 (Date rec'd by registrar) DEC 11 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1948; at 8.25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945 to Dec. 10 1948 and that I last saw Walburga alive on Dec. 10 1948.

Immediate cause of death	Duration
(1) Cerebral Hemorrhage	5 days
Due to Hypertensive Cardio Vascular Disease	10 yrs
Due to	
Other Conditions Diabetes Mellitus	70 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M.D.
Address 4108 Liberty Hts Ave Date signed 12/11/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

937

69355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69355

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. 0. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Briscoe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LONNIE POWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Wilson, N.C.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Lawene Powell
13. Birthplace Rock Mount, N.C.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant: Deronica Powell
(b) Address 1127 Briscoe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cem.
Location Baltimore City

18 (a) Funeral director Joseph A. Lively
(b) Address 661 West Barre Street

19 (a) DEC 11 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1948, at 10:10 M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH A.S.C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rose M.D.
Medical Examiner.
Date signed Dec. 9, 1948

VS 151

correct age is especially important for persons 70 years and over, and for children under 5 years

669356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

669356 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Give the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 N. Eutaw street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 N. Eutaw street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME JOHN A. DEVALL

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 218-010-756

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1878

8. AGE: Years	Months	Days	If less than one day
70	3	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Devall
13. Birthplace Camden, N.J.

MOTHER
14. Maiden Name Annie M. Ward
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Catherine A. Devall
(b) Address 1102 N. Eutaw street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Chas. D. Evans Son Inc
(b) Address 118 N. Mt. Royal Ave

DEC 11 1948 (Date rec'd by registrar) (b) Frederick, Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1948 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1948 to Dec 10 1948 and that I last saw h alive on Dec 8 1948.

Immediate cause of death	Duration
Acute Cardiac Dilatation	10 days
Due to Hypertensive Cardio-Vascular disease	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Steersman M. D.
Address 753 W. Fayette St Date signed Dec 11 1948

VS 150

G69357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69357

PLEASE WRITE PLAINLY, WITH UNFADING INK. ENTRIES MUST BE MADE ON THIS CERTIFICATE. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2930 St. Paul street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 St. Paul street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD L. GILL

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-16-1723

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Karolyn Arnold Gill

6 (c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): April 20, 1873

8. AGE: Years 75 | Months 7 | Days 20 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Accountant
11. Industry or business: (retired)

FATHER
12. Name: Peter Gill
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Clabey
15. Birthplace: Ireland

16 (a) Informant: Mr. Edward Gill
(b) Address: 2930 St. Paul street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/13/48 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location:

18 (a) Funeral director: Chas. J. Evans Son Inc.
(b) Address: 118 W. Mt. Royal Ave.

19 (a) DEC 11 1948 (Date rec'd by registrar) (b) [illegible] for Wilhelmina M. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1948, to Dec. 10 1948, and that I last saw h[illegible] alive on Sept 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	2 hrs
Due to Myocarditis	3 yrs.
Due to Arteriosclerosis	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Thomas F. Mudd M. D.
Address: 3809 Greenmount Ave. Date signed: 12/14/48

VS 150

X

9358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 69358

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2220 Mt. Holly St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Mt. Holly St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cora E. Fox

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Grover C. Fox
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Feb. 13. 1885

8. AGE: Years	Months	Days	If less than one day
63 6Y	109	15	hr. min.

9. Birthplace Penna/Virginia (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name John D. Kane
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary Will
15. Birthplace Penna

16 (a) Informant Grover C. Fox
(b) Address 2220 Mt. Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn Md

18 (a) Funeral director Thomas J. Kenny Inc
(b) Address 1600 Hollins St.

19 (a) DEC 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 8 - 1948 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1946 to 12-8- 1948 and that I last saw him alive on 12-7- 1948

Immediate cause of death	Duration
Arteriosclerotic heart disease	3 years
Due to Hypertension	2 1/2 yrs
Due to Gen. Arterio Sclerosis	2 yrs
Other Conditions Coronary Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Nicholaus M. D.
Address 2230 Eutaw Pl Date signed 12/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Any error, omission or unknown must be corrected. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

G69359

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G69359

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2200 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY GANZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Fredericka S. Ganz
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Nov. 29, 1874

8. AGE: Years	Months	Days	If less than one day
74	0	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Confectioner -retired
11. Industry or business Self

FATHER
12. Name John Ganz
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. Schlaich
15. Birthplace Germany

16 (a) Informant Mr. Carl W. H. Ganz
(b) Address 13 Aintree Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1948, at 5:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17 1948 to 12/9 1948 and that I last saw h[illegible] alive on 12/9 1948.

Immediate cause of death Thrombosis — Duration 3 weeks
Due to Arteriosclerosis & Coronary Thrombosis — Duration 4 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Palagia M. D.
Address 3326 Eastern Ave. Date signed

Correct age is especially important. If uncertain, say so.

VS 150

69360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69360

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2535~~ Edmondson Ave.
(c) Hospital or institution 2535

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~2535~~ 2535 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? ~~Md~~ (Yes or No)
If yes, name country

3 (a) FULL NAME META WURZBACHER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-10-8409

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: -

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1884

8. AGE: Years 64 | Months 4 | Days 6 | If less than one day: hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Tie Maker

11. Industry or business Harcum, Inc.

FATHER
12. Name John L. Wurzbacher
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Margaret Schmitt
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Charles E. Koontz,
(b) Address 2535 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date rec'd by Registrar (b) Huntington Williams, M.D. Registrar

correct age is especially important; physicians, please write

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1948 at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-27-1948 to Dec 10-1948 and that I last saw h[illegible] alive on Dec 10-1948

Immediate cause of death: Dilatation of Heart — Duration: 14 da.

Due to: Fatty Degeneration of Heart — Duration: unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ~ at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chester Riland M.D.
Address 2532 Edmondson Ave. Date signed 12-11-48

VS 150

X

G69361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7313 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE R. UNGER

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Aber D. Unger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1889

8. AGE: Years 59 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace: Indianapolis, Ind.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William Shane
13. Birthplace: Austria-Hungary

MOTHER
14. Maiden Name: Mary Spielberger
15. Birthplace: Austria-Hungary

16 (a) Informant: Aber D. Unger
(b) Address: Apt. 207, Greenspring Manor Apts. 7313 Park Heights Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/11/48 (month) (day) (year)
(c) Cemetery or crematory
Location: Cleveland, Ohio

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) DEC 11 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/10/48 1948 at 11 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1b 1948, to 12/10 1948, and that I last saw her alive on 12/10 1948.

Immediate cause of death: Cerebral hemorrhage HT Disease — Cardiac decompensation — Duration

Due to

Due to

Other Conditions: Pulmonary infarction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury NORMAN MC MANN, M.D.

23. Signature [signature]

Address [illegible] Date signed 12/10/48 M. D.

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PROUT

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46F

1. PLACE OF DEATH — Registered No. 693362

CITY OF BALTIMORE: (No. 408 Presstman St. Ward 13) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 5yr mos ds. How long in U. S. If of foreign birth? yrs mos ds.

2. FULL NAME Howard M. Prout — If U. S. Veteran specify WAR

(a) Residence: No. 403 Presstman St., Ward. (Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	Col	married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Sept 17 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	2	20	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME Albert Prout

14. BIRTHPLACE (city or town) (State or country) Balto Md

MOTHER

15. MAIDEN NAME Georgiana Palmer

16. BIRTHPLACE (city or town) (State or country) Balto Md

17. INFORMANT Mary F Prout

(Address) 403 Presstman St

18. BURIAL, CREMATION, OR REMOVAL

Place Mt Auburn Date 12/12 19 48

19. UNDERTAKER Isaac L Brown Son

(Address) 408 W Montgomery St

20. FILED DEC 11 1948 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec 7, 19 48

22. I HEREBY CERTIFY, That I attended deceased from Oct. 1 19 48 to Dec 7 19 48

I last saw h[illegible] alive on Dec 5 19 48 Death is said to have occurred on the date stated above, at 9:45 P.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of liver	?
Other contributory causes of importance:	
Carcinomatosis	?

Was an operation performed? no Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no If so, specify

(Signed) Bernard Harris M. D.

(Address) 1202 N Caroline St.

OCCUPATION is very important. See instructions on BACK OF CERTIFICATE.

VS 3

669363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. 669363

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in permanent black ink or typewritten. Physicians: please write the causes of death clearly and legibly. Please see that age is correctly stated. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1632 MILLER St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 MILLER St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME PRISCILLA J. THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C.	Widow

6 (b) Name of husband or wife WM. J. THOMAS
6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) 3 - 8 - 1873

8. AGE: Years	Months	Days	If less than one day
75	9	-	hr. min.

9. Birthplace Dorchester County, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John STANLEY
13. Birthplace Md

MOTHER
14. Maiden Name ANNIE BURRS
15. Birthplace Md

16 (a) Informant Florence Ross
(b) Address 1632 MILLER St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-13-48 (month) (day) (year)
(c) Cemetery or crematory Mt. PLEASANT
Location SALEM, Md.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1306 N. Central Ave Huntington Williams, Md

DEC 11 1948 (Date) (By) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 8 1948 at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948 to Dec 8 1948.
and that I last saw h alive on Dec 8 1948.
Immediate cause of death Acute Insufficiency

	Duration
	Complete
Due to	
Due to	
Other Conditions Bronchial Pneumonia, Chronic Nephritis (Include pregnancy within 3 months of death)	Complete

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph L. Young M. D.
Address 1424 E. Monument St. Date signed

92a

VS 150

69364 #7447 B.C. 48-25 490

SIROVIC ✓

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161a

Registered No. G69364

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2642 McElderry St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald Sirovic

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-21-48

8. AGE: Years | Months | Days: 19 | If less than one day: hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Joseph Sirovic
13. Birthplace: Penn

MOTHER 14. Maiden Name: Josephine BROMEK
15. Birthplace: Penn

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 13 1948 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location 4200 BELAIR RD.

18 (a) Funeral director DIPPEL BROTHERS
(b) Address 1800 E LOMBARD ST.

19 DEC 11 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1948, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8- 1948 to 12-10 1948 and that I last saw him alive on 12-10 1948.

Immediate cause of death: Cardiac failure — Duration:
Due to: Congenital
Due to: atelectasis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature a. c. Lang M. D.
Address Johns Hopkins Hosp Date signed 12-10-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 193

X

44988 69365

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

Registered No. 69365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A.
(c) City or town West ANNAPOLIS
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Sylcrest Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boy-Baby "Margaret" Baker Henry Heaton Baker 3rd

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-7-48

8. AGE: Years	Months	Days	If less than one day
		5-4	hr. min.

9. Birthplace Johns Hopkins Hospital, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Baker Jr.
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Jorgersen
15. Birthplace N.Y.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 12-13-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Valley Forge Penna

18 (a) Funeral director A. J. Tschantz & Son
(b) Address Baltimore Md

DEC 12 1948
(Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948 at 3 16 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7- 1948 to 12-11- 1948 and that I last saw h. in alive on 12-11- 1948.

Immediate cause of death Circulatory failure — Duration
Due to Congenital Heart Desease
Due to Ebstonis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: 12-11-48 yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles E. Flowers Jr. M. D.
Address Johns Hopkins Hosp Date signed Dec 14 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 153

G69366 BALTIMORE CITY HEALTH DEPARTMENT G69366

CERTIFICATE OF DEATH 146a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 731 So. Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia E. Roberts 48-26910

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Jack A. Roberts (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1921

8. AGE: Years	Months	Days	If less than one day
27	4	2	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Jack A. Roberts
(b) Address 731 - S. Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14-48 (month) (day) (year)
(c) Cemetery or crematory McNealey Cemetery
Location Hendricks - W. Va.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) DEC 12 1948 (Date rec'd by registrar) (b) Huntington, W. Va. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1948, at 12" P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1948, to Dec 10 1948, and that I last saw her alive on Dec 10 1948.

	Duration
Immediate cause of death Virginia Paralytic Ileus	
Due to Wound Dehiscence DEHISCENCE	
Due to Shock, cause Undetermined	over
Due to Caesarean Section	
Placenta Praevia, Partialis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Dec 5, 1948 + Dec 8
Major findings of operation: Placenta Praevia
2° Wound Dehiscence - 2nd Operation
of autopsy: Deferred for Microscopic Study

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas J. Frost M. D.
Address 536 H Date signed Dec 11, 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. G69367

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 211
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
U.S.Marine Hospital,
(d) Street No. Wyman Park Drive & 31st St.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME Daily, Virginia Caroline

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6 (c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.) 8/26/1913

8. AGE: Years 35 | Months 3 | Days 16 | If less than one day: hr. min.

9. Birthplace Chase City, Virginia
(Town, county, and state)

10. Usual Occupation Dietitian

11. Industry or business Hospital

FATHER
12. Name Logan Daily
13. Birthplace North Carolina

MOTHER
14. Maiden Name Josephine Bridges
15. Birthplace North Carolina

16 (a) Informant Records
(b) Address U.S.Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14-48 (month) (day) (year)
(c) Cemetery or crematory Boydton Va
Location Boydton Va.

18 (a) Funeral director E. Haworth Armacost
(b) Address 3911 Liberty Heights Ave

1948 DEC 12 (Date rec'd by registrar) (b) Huntington White, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1948, at 7:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14, 1948 to Dec. 11, 1948, and that I last saw her alive on Dec. 11, 1948.

Immediate cause of death	Duration
Adenocarcinoma of left ovary	
with generalized metastases	7 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surg. Clinical Dir. USPHS
Address U.S. Marine Hosp. Date signed 12/11/48

PLEASE WRITE PLAINLY, with unfading ink. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69368

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95B

Registered No. G69368

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1719 Hollins St
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willard H. Rollins

3 (b) If veteran, name war None
3 (c) Social Security Account No. 216-14-1865

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edna A. Rollins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 17, 1901

8. AGE: Years 45 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Bedford Co Penna (town, county, and state)
10. Usual Occupation Burner
11. Industry or business Ship Yard

FATHER
12. Name Frank Rollins
13. Birthplace Bedford Co Penna

MOTHER
14. Maiden Name Bessie Burkett
15. Birthplace Bedford Co Penna

16 (a) Informant Edna A. Rollins
(b) Address 1719 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Pratt Geyser Wive & B. M. Walters
(b) Address Pratt + Stricker St

19 Filed Dec 12 1948 (Date rec'd by Registrar) Huntingtown Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 19 48 to Dec 11 19 48, and that I last saw h[illegible] alive on Dec 11 19 48.

Immediate cause of death Cerebral Thrombosis — Duration 3 mos.
Due to
Due to
Other Conditions Rheumatic Heart Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. B. Schreiber M. D.
Address 54 S. Fulton Ave. Date signed 12-11-48

correct age is especially important. Physicians: please write the exact

VS 130

G69369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3917 Forest Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis B. Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lena B

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1874

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Lith

MOTHER
14. Maiden Name Not Known
15. Birthplace Lith

16 (a) Informant Lena Hoffman
(b) Address 3917 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men's
Location Windsor Mills Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 DEC 12 1948 (b) Huntington Williams, Registrar
(Date rec'd by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 1948, at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1948 to 12/11 1948, and that I last saw him alive on 12/11 1948.

Immediate cause of death Uremia — Duration

Due to Cerebrovascular Accident

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leopard Hoffman M.D.
Address Sinai Hospital Date signed 12/12/48

correct age is especially important. Physicians, please write plainly. Use ink.

VS 150

G69370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69370

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospt
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4110 Forest Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herman Michelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1886

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace U. S. A. (Town, county, and state)

10. Usual Occupation Engraver

11. Industry or business

MOTHER | FATHER

12. Name Simon

13. Birthplace U. S. A.

14. Maiden Name Elkes

15. Birthplace U. S. A.

16 (a) Informant Wife

(b) Address 4110 Forest Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location Balto & Conkelin St

18 (a) Funeral director Park Lewis Inc

(b) Address 2100 Eutaw Pl.

19 DEC 12 1948 (Date rec'd by registrar) (b) Huntington Williams Mort

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1948, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1948 to 12-10 1948, and that I last saw h[illegible] alive on 12-10 1948.

Immediate cause of death Myocardial infarction — Duration

Due to Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jerome Gabler M. D.

Address Sinai Hosp. Date signed 12-10-48

correct age is especially important. Physicians: please write the cause of death clearly. Do not use abbreviations.

VS 150

G69371 BALTIMORE CITY HEALTH DEPARTMENT G69371

CERTIFICATE OF DEATH

61 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as required by law. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE & JOHN STS.
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MARYLAND
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 48 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 SEQUOIA AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE KRIEGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife ISAAC KRIEGER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. year not known

8. AGE: Years	Months	Days	If less than one day
Abt 70	3		hr. min.

9. Birthplace LITHUANIA
(Town, county, and state)
10. Usual Occupation NONE.
11. Industry or business

FATHER
12. Name JACOB WARKEL
13. Birthplace LITHUANIA

MOTHER
14. Maiden Name LIBA - NOT KNOWN
15. Birthplace LITHUANIA

16 (a) Informant MAX A. KRIEGER
(b) Address 3942 LYNCHESTER RD -

17 (a) Burial (b) Date thereof 12-12-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia & Hamilton Ave

18 (a) Funeral director Jack Lewis, Inc.
(b) Address 2106 Eutaw Place

19 (a) DEC 12 1948 Washington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10/48 1948, at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10/48 19__, to DEATH 19__, and that I last saw her alive on 12/10/48 19__.

	Duration
Immediate cause of death CARDIAC FAILURE	
Due to ARTERIOSCLEROTIC HYPERTENSIVE CARDIOVASCULAR DISEASE	15 years
Due to	
Other Conditions DIABETES MELLITUS	20 years.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mark E. Hall, M.D.
Address Women's Hospital Date signed 12/10/48

VS 180

93

G69372

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G69372 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 50yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 No Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis A. Gross

3 (b) If veteran, name war

3 (c) Social Security Account No. 299-10-0870

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Moses
13. Birthplace Austria

MOTHER
14. Maiden Name Helen
15. Birthplace Austria

16 (a) Informant Paul Gross
(b) Address 11 E. 199th St New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-48 (month) (day) (year)
(c) Cemetery or crematory Ohel Shalom
Location O'Donnell St

18 (a) Funeral director Jack Lewis Inc
(b) Address 216 Eutaw Place

19 (a) DEC 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 - 1948, at 2:14 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9- 1948 to 12-10-1948, and that I last saw h alive on 12-10-1948.

Immediate cause of death	Duration
Acute myocardial infarction with Congestive heart failure	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Hand M. D.
Address Sinai Hosp. Date signed 12-10-48.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69373 ✓ G69373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2019 Wilkens Ave
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Celia Bergen

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Not Known
13. Birthplace Russia

MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Joseph Bergen
(b) Address 3802 Fairwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

19 (a) DEC 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 10 - 1948 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8, 1948 to Dec 10, 1948 and that I last saw h alive on Dec. 9, 1948.

Immediate cause of death: Carcinoma of Stomach with metastases — Duration: at least 3 mos.

Due to —

Due to —

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan H. Shpritz M. D.
Address 1810 Eutaw Pl Date signed 12/10/48

VS 150

X

G69374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G69374 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2717 Miles Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Miles Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie M. Bradford.

3 (b) If veteran, name war ------

3 (c) Social Security Account No. 218-09-9756

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife William Bradford.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 8, 1891

8. AGE: Years 57 | Months 4 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Lloyd Kidd.
13. Birthplace Md.

MOTHER
14. Maiden Name Susan Riley.
15. Birthplace Md.

16 (a) Informant Bernice O. Ray.
(b) Address 2825 Hampden Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Dec. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Pine Grove.
Location Baltimore County.

18 (a) Funeral director Paul E. Chenoweth Jr.
(b) Address 3615-17 Chestnut Ave.

19 (a) DEC 12 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1948, at 2.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1948, to 12/7 1948.
and that I last saw her alive on 12/7 1948.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions Hypertension & Cardiac Enlargement
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Legum M.D.
M. D.

Address 1261 E. North Ave Date signed 12/10/48

correct age is especially important. Physicians: please write the cause of death very plainly.

VS 150

669375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ 663625

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224 N. Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N. Lanvale St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Beulah Hooper

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Upshur Hooper
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 3 1882

8. AGE: Years 66 | Months 11 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Darlington Md
(Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name George D. Whitelock
13. Birthplace Darlington, Md

MOTHER
14. Maiden Name Annie Hopkins
15. Birthplace Darlington Md

16 (a) Informant Marjory Whitelock
(b) Address Gilman apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13 1948 (month) (day) (year)
(c) Cemetery or crematory Darlington
Location Darlington Md

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address 4905 York Rd 12

19 (a) DEC 12 1948 (Date rec'd by registrar) (b) Darlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1947, to Dec 11 1948, and that I last saw her alive on Dec 6 1948.

Immediate cause of death Coronary Thrombosis — Duration 14 yrs.
Due to arterial sclerosis.
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Harry D. McCarty
Address 37 W. Preston St. Date signed 12/11/48 M. D.

VS 150

G69376

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

Registered No. G69376

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey Street
(c) Hospital or institution:
Good Samaritan Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5719 Bellona Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Wardwell Humrichouse

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. H. Humrichouse, Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August-24-1887

8. AGE: Years	Months	Days	If less than one day
61	3	16	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Fitzhugh Hiliar Wardwell
13. Birthplace England

MOTHER
14. Maiden Name ? ? Otis
15. Birthplace Virginia

16 (a) Informant Mr. Wm. H. Humrichouse, 3rd. (son)
(b) Address 5719 Bellona Avenue, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec-13-1948 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue, City #1.

19 (a) DEC 12 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10/48 19 , at 10 A M

21. I certify that death occurred on the date above stated that I attended deceased from Dec 9 1948, to 12/10 1948, and that I last saw h[illegible] alive on 12/9/48 19 .

Immediate cause of death: Mitral valve disease — Duration: 2 mos
Due to: Paralysis agitans — 4 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter J. Stowe
Address Fair Edmondson Date signed 12/10/48 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 153

G69377 ✓ G69377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3113 Windsor Ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Windsor Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland R. Harmon

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Raye M. Harmon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1888

8. AGE: Years 60 | Months 0 | Days 14 | If less than one day hr. min.

9. Birthplace Jeffersonville, Ill.
(Town, county, and state)

10. Usual Occupation Office Manager

11. Industry or business Hellenic Bros.

FATHER
12. Name Emory Mason Harmon
13. Birthplace Illinois

MOTHER
14. Maiden Name Minta A. Harmon
15. Birthplace Illinois

16 (a) Informant Mrs. Raye M. Harmon
(b) Address 3113 Windsor Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) DEC 12 1948 (Date rec'd by registrar) Clifton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1948 at 2.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1948. to Dec. 10 1948., and that I last saw him alive on Dec. 10 1948.

	Duration
Immediate cause of death Myocardial failure of unknown etiology	7
Due to Possibly renal failure	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob E Schmidt M. D.
Address 2924 Brighton St Date signed 12-11-48

VS 150

G69378 ✓ G69378

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 164a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Rolling Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ann C. Rittinger

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3 1908

8. AGE: Years	Months	Days	If less than one day
40	7	8	hr. min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George R. Gibson
13. Birthplace Pholadelphia Pa.

MOTHER
14. Maiden Name Anna Calvin
15. Birthplace Philladelphia Pa.

16 (a) Informant Mr. George J. Rittinger
(b) Address 504 Rolling Rd.

17 (a) Burial (b) Date thereof Dec. 15 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Montrose Cemetery
Location Upper Darby Pa.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 DEC 12 1948 Victor Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11/48 19 at 12:10 PM

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Strangulation

Due to

Other Conditions Marked mental depression
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/11/48 at 12 P. M.
(b) Where did injury occur? 504 South Rolling Road Catonsville Maryland
(c) Did injury occur at home, on farm, industrial place, in public place? None While at work? no
(d) Means of injury Hung self with bath Robe tied

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 12/11/48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 151

G69379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G69379 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 S. Augusta Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 S. Augusta Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Atwell Hanton

3 (b) If veteran, name war	3 (c) Social Security Account No.
M	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Anna M. Hanton
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Mar. 22, 1854

8. AGE: Years	Months	Days	If less than one day
94	8	18	hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Nathan A. Hanton
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary A. Cole
15 Birthplace Maryland

16 (a) Informant Lydia Elderkin
(b) Address 305 S. Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) DEC 16 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1946, at 3:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 1 1926 to Dec - 10 1946, and that I last saw him alive on Dec - 9 - 1946

Immediate cause of death: Nephritis - Chronic Arterio-Sclerotic — Duration: years

Due to: Senility & Arterio-Sclerosis. 5-10 yrs.

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. Lloyd Johnson M.D.
Address Catonsville Date signed 12/10/46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G69380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

G69380 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Dr. and 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Rockville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Claridge Road, Rt. 4
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Terry Dean MILLER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 3, 1940

8. AGE: Years 8 | Months 1 | Days 8 | If less than one day: hr. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Kenneth Miller
13. Birthplace Iowa

MOTHER
14. Maiden Name Mary Vogel
15. Birthplace Nebraska

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14 1948 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem
Location Rockville Md

18 (a) Funeral director Warner E. Pumphrey
(b) Address Silver Springs Md

19 (a) [illegible] Washington Grove Md
(Date received by Registrar) Registrar

DEC 12 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1948, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27, 1948, to Dec 11, 1948, and that I last saw h im alive on Dec 11 1948

Immediate cause of death	Duration
Leukemia, acute, with generalized lymphadenopathy	unkn
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature David D. Edwards M. D.
Address U.S. Marine Hospital Baltimore, Md. Date signed 12/13/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G 69381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. If unknown, insert "unknown" or "none" where necessary. Physicians: please write the causes of death clearly and legibly. Give correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Dr. and 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 3924 Glendale St., (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Ralph Allan WILLS

3 (b) If veteran, name war: WW II
3 (c) Social Security Account No.: ?

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ida May Wills
6 (c) If alive, give age: 43 years
7. Birth date of deceased (mo., day, yr.): Sep 21, 1908
8. AGE: Years 40 | Months 2 | Days 20 | If less than one day: hr. min.
9. Birthplace: Florida (Town, county, and state)
10. Usual Occupation: none
11. Industry or business:

FATHER
12. Name: Josiah Willa,
13. Birthplace: New Jersey

MOTHER
14. Maiden Name: Mary Ellen Clarkson
15. Birthplace: Pennsylvania

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 13 48 (month) (day) (year)
(c) Cemetery or crematory: Philadelphia
Location: Philadelphia, Penna

18 (a) Funeral director: Wm Cogh Inc
(b) Address: Baltimore Md

19 (a) DEC 13 1948 (Date received by registrar) (b) Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1948 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 13 1948 to Dec 11 1948 and that I last saw him alive on Dec 11, 1948.

Immediate cause of death: Malignant melanoma with metastasis to anterior chest wall, left axilla and mesenteric lymph nodes — Duration: unkn

Due to:

Other Conditions: Peritonitis

(Include pregnancy within 3 months of death)

Date of operation: Aug 7, 1945

Major findings of operation: Neck dissection - as above

of autopsy: as above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David D. LeGrand M.D.
David D. LeGrand, M. D.
Address Marine Hospital Date signed 12/12/48

VS 150

9382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G69382 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital 9-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35da.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 E. 31st St., Balto.-18 Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Mongin German

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe.	White	Widow

6 (b) Name of husband John German
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1887

8. AGE: Years	Months	Days	If less than one day
61		3	hr. min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Hwfe.
11. Industry or business

FATHER
12. Name Robert M Mongin
13. Birthplace Ga.

MOTHER
14. Maiden Name Anna Ridgley
15. Birthplace Fla.

16 (a) Informant John German
(b) Address 1721 E. 31st St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/14/48 (month) (day) (year)
(c) Cemetery or crematory Laurel Grove
Location Savannah Ga.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 DEC 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1948, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6/ 1948 to 12/11/ 1948, and that I last saw her alive on 12/11/ 1948

Immediate cause of death: Uremia — Duration: 20 days

Due to Carcinoma of uterus c metastasis to bladder — 5yrs

Due to

Other Conditions Terminal pneumonia

(Include pregnancy within 3 months of death)
Date of operation 11-19-48
Major findings of operation: Metastatic CA - bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Ehrlich
Address St Joseph Hosp. Date signed 12/11/48

correct age is especially important. Physicians: please write the cause of death plainly.

1383 H. BAKER

BALTIMORE CITY HEALTH DEPARTMENT ✓ 669383

CERTIFICATE OF DEATH 20

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Carrie r Saratoga Sts.
(c) Hospital or institution:
Mercy Hosp. 6.
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs 3mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ——
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Hilda Baker

3 (b) If veteran, name war ——

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband ~~or wife~~ Francis D. Baker
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) August 31, 1916

8. AGE: Years	Months	Days	If less than one day
32	3	11	..... hr. ..... min.

9. Birthplace Unknown
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business Home.

FATHER
12. Name Joseph D. Rivers
13. Birthplace Unknown

MOTHER
14. Maiden Name Lillie Goodwin
15. Birthplace Unknown.

16 (a) Informant Francis D. Baker
(b) Address 2102 E. Balto. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/48 (month) (day) (year)
(c) Cemetery or crematory Ft Lincoln MD
Location Baltimore MD

18 (a) Funeral director Williams & Son
(b) Address 1219 E. Pond St.

19 (a) DEC 13 1948 (Date rec'd by registrar) (b) Huntington for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1948, at 4 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1948 to 12/11 1948, and that I last saw h er alive on 12/11 1948.

Immediate cause of death	Duration
Uremic Acidosis	
Due to Renal Tuberculosis	- 3yrs?
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. M. Emerson M. D.
Address Mercy Hosp. Date signed 12/11/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G69384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. G69384

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 W. 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 West 30th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country (Naturalized U.S.A.)

3 (a) FULL NAME JOSEPHINE A BARANY HARSTALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married (Spinster)

6 (b) Name of husband or wife Alexander Harstall
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1879

8. AGE: Years	Months	Days	If less than one day
69	2	20	hr. min.

9. Birthplace Arad, Hungary (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Paul Barany
13. Birthplace Hungary (Cegled)

MOTHER
14. Maiden Name Josephine Oberszt
15. Birthplace Hungary

16 (a) Informant daughter - Leonora Harstall
(b) Address 329 West 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location Baltimore Md

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave & Fayette St

19 DEC 13 1948 (Date rec'd by registrar) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1948 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1948 to December 12 1948 and that I last saw her alive on Dec. 8 1948.

Immediate cause of death Respiratory failure — Duration

Due to Carcinomatosis

Due to Pelvic carcinoma (type unknown (Ovarian?)) — 2½ years

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James W. C. Finney M. D.
Address Union Memorial Hospital Date signed Dec. 12, 1948

correct age is especially important. Physicians, please write plainly.

VS 150

X

G69385 B.C. 48-27590

BALTIMORE CITY HEALTH DEPARTMENT ✓ G69385

CERTIFICATE OF DEATH 160a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski Sts
(c) Hospital or institution:
Bon Secours Hospital. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11hrs 10min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Baby Kavanaugh.~~ Baby Cavanaugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1948

8. AGE: Years	Months	Days	If less than one day
			11hrs. 10mins.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Philip Richard Kavanaugh.
13. Birthplace Baltimore, Maryland.

MOTHER
14. Maiden Name Jeane Margaret Metusaveg.
15. Birthplace Baltimore, Maryland.

16 (a) Informant Mr Philip R. Kavanaugh.
(b) Address 1800 W. Fayette St.

17 (a) Dec. 13, 1948 (Burial, cremation, or removal) (b) Date thereof Burial (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location Baltimore, Md

18 (a) Funeral director George A. Fatley
(b) Address Fulton Ave. & Fayette St.

19 DEC 13 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11-48 19 . at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1948 to 12-11 1948, and that I last saw h.m alive on 12-11 1948.

Immediate cause of death Intracranial Hemorrhage (Birth Injury)

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Attending

Address Bon Secours Hosp Date signed 12-14-48

PLEASE WRITE PLAINLY, with ordinary pen and ink. Do not use pencil. Do not fold. Do not roll. Be sure to answer every question. If none, write none, or insert 0 (cipher) where the question applies. Do not leave any blanks. Make no erasures. Do not abbreviate. Write out the full name of the month. Do not use ditto marks. Be sure to give the correct age in each case. Physicians: please write the causes of death clearly and legibly.

G69386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G69386 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Sinai 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 270 Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Harry Weiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Katie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1888

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60	1			

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Simon
13. Birthplace Russia

MOTHER 14. Maiden Name Fannie
15. Birthplace Russia

16 (a) Informant Katie Weiner
(b) Address 270 Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jac C Lewis Inc
(b) Address 2400 Eutaw Place

19 DEC 13 1948 (Date rec'd by registrar) (b) Funeral for Williamsport

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12 1948, at 8 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1948, to 12/12 1948, and that I last saw h alive on 12/11 1948.

Immediate cause of death	Duration
Peripheral Circulatory Collapse	
Due to Generalized Carcinomatosis	
Due to Carcinoma of Bladder	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation March 1948
Major findings of operation: Carcinoma of Bladder
of autopsy: No Post Mortem

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benson Schwartz M. D.
Address Sinai Hosp. Date signed 12/13/48

9387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G69387

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution: Sinai 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

2

(d) Street No. 2213 Lenden Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME SOFIE ~~Schwarz~~ SCHWARZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Moriz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1871

8. AGE: Years 77 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Anton

13. Birthplace Hungary

MOTHER 14. Maiden Name Anna

15. Birthplace Austria

16 (a) Informant Walter F Schwarz

(b) Address 2210 Lenden ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila Rd Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2160 Eutaw Place

19 (a) DEC 13 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 1948 at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1948 to 12/11 1948 and that I last saw her alive on 12/11 1948.

Immediate cause of death	Duration
MYOCARDIAL INFARCTION	
GANGRENE OF LEGS	
Due to CORONARY SCLEROSIS	
Due to SADDLE EMBOLISM	
Other Conditions Pericarditis - Gangrene of legs due to saddle embolism (Include pregnancy within 3 months of death)	

Date of operation 12/9/48

Major findings of operation: Saddle Embolism

of autopsy: same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Barnard Schwartz M.D.

Address Sinai Hospital Date signed 12/12/48

VS 150

X

69388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 69388

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 138 Willard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 Willard Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME William L. S. Taylor

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1886

8. AGE: Years 62 | Months 9 | Days 26 | If less than one day: hr. min.

9. Birthplace: Virginia
(Town, county and state)

10. Usual Occupation: Retired
W

11. Industry or business

FATHER
12. Name: William P. Taylor
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Mary Hankins
15. Birthplace: Virginia

16 (a) Informant: Miss Ada Taylor
(b) Address: 138 Willard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48 (month) (day) (year)
(c) Cemetery or crematory: WESTERN
Location: BALTIMORE

18 (a) Funeral director: John T. Stansbury
(b) Address: 2700 Edmondson Ave.

19 DEC 13 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 48 to Dec 11 19 48 and that I last saw him alive on Dec 5 19 48

Immediate cause of death: Cardio vascular collapse

Duration: 1 day

Due to: Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Mackey M. D.
Address 2030 Wilkens Ave Date signed Dec 13 1948

VS 153

correct age is especially important. Physicians, please

X

G69389

B.C.-7-6810C

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 54a

G69389 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Green St.
(c) Hospital or institution: University Hospital 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 Dys
(e) Length of stay in Baltimore (yrs., mos., or days): 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 5426 Jonquil Ave. (If rural give location)
(e) Citizen of foreign country?: NO (Yes or No)
If yes, name country:

3 (a) FULL NAME: Charles H. Rush

3 (b) If veteran, name war: Child
3 (c) Social Security Account No.: NO

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Child
6 (b) Name of husband or wife:
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 26, 1943
8. AGE: Years: 5 | Months: 11 10 | Days: 15 | If less than one day: hr. min.
9. Birthplace: Baltimore, ?Maryland (Town, county, and state)
10. Usual Occupation: Child
11. Industry or business: W

FATHER
12. Name: Willard C. Rush
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Anna E. Hamilton
15. Birthplace: California

16 (a) Informant: Mr. Willard C. Rush
(b) Address: 5426 Jonquil Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/14/48 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn, Md.

18 (a) Funeral director: John T. Stansbury
(b) Address: 2700 Edmondson Ave.

19 DEC 13 1948 (Huntington Williams, M.D. Registrar)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11 1948, at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Dec 1948 to 11 Dec 1948, and that I last saw him alive on 11 Dec 1948.

Immediate cause of death: Respiratory failure
Due to: Cerebellar tumor malignant, astrocytoma
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: 11 Dec 1948
Major findings of operation: Cerebellar astrocytoma
of autopsy: same

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. A Alvarez-de Choudens M.D.
Address: University Hospital Date signed: 11 Dec 1948

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

69390 ✓ G69390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 247 N. Carey St
(c) Hospital or institution: Good Samaritan Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Westwood St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Essex Co Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Horace Byrd
13. Birthplace Va

MOTHER
14. Maiden Name Alice ?
15. Birthplace Va

16 (a) Informant Roberta Phillips
(b) Address 1003 N Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore County

18 (a) Funeral director Wm B Jackson
(b) Address 916 Pulton Av

19 (a) DEC 13 1948 (Date rec'd by registrar) (b) Interment for Williamsburg Va

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11/48 19 at 6a M

21. I certify that death occurred on the date above stated, that I attended deceased from 12/3/48 19 to 12/11/48 19, and that I last saw h[illegible] alive on 12/9/48 19.

Immediate cause of death Myocarditis — Duration [illegible]

Due to Carcinoma Intestine

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm B Jackson

Address 401 Edmondson Date signed 12/11/48 M. D.

correct age is especially important. Physicians: please write the cause of death plainly and legibly.

VS 150

69391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G69391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 Norris
(c) Hospital or institution:
University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Cnty
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Norris St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	B	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Lynchburg Va.
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Ben Miller
13. Birthplace Va

MOTHER
14. Maiden Name ? unknown
15. Birthplace unknown

16 (a) Informant Alberta Miller
(b) Address 505 Norris St

17 (a) Burial (b) Date thereof 12/14/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave

19 (a) DEC 13 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1948 at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1948 to 12-10 1948
and that I last saw h alive on 12-10 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Dehydration + Acidosis	
Due to Hyperglycemia	
Other Conditions Diabetic Coma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. C. Smith, M.D.
M. D.
Address Univ. Hospital Date signed 12-10

VS 150

Turnbull for Millard, Md

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

$69392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. G69392

LCH - 124822

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Mosher Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME HENRY JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?/?/?

8. AGE: Years	Months	Days	If less than one day
? 78			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte ?
15. Birthplace Maryland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Wm A Jackson
(b) Address 916 Pentra

19 (a) DEC 13 1948 (Date rec'd by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/9/48 19 , at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/48 19 to 12/9/48 19 , and that I last saw him alive on 12/9/48 19 .

Immediate cause of death Bronchopneumonia Pulmonary Infarction — Duration

Due to Thrombosis of Pelvic Veins,

Due to

Other Conditions Cardiac Hypertrophy & Dilatation; Ca of Prostate (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. Lanza M. D.
Address Balt. City Hosp Date signed 12/10/48

G69393

AB-125154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. G69393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Marshall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith F. Purdy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James J. Purdy
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 2- 1887

8. AGE: Years 61 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland (Howard Co.)
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John F. Cole
13. Birthplace Va.

MOTHER
14. Maiden Name Florence L. Bosley
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave. Son-Allen R. Cole

17 (a) Burial — **(b) Date thereof** Wed. Dec. 15, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St. Balto. 30

19 (a) DEC 13 1948 **(b)** Huntington Williams, M.D.
(Date received by local registrar) (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sun. Dec. 12- 1948, at 7.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7- 1948 to 12-12- 1948 and that I last saw her alive on 12-12- 1948.

Immediate cause of death Meningitis, etiology ab. fine

Due to Aortic insufficiency, cause?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. T. Welsh M.D.
Address BCH **Date signed** 12-13-48

V S 150

PLEASE WRITE PLAINLY, with ink. Please answer all questions. Be sure that you correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 669394

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3425 Belair Road,
(c) Hospital or institution: 26 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3425 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter Blum

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Barbara A. Blum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1865

8. AGE: Years	Months	Days	If less than one day
83	0	2	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Blum
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Edwin Blum
(b) Address 1540 Lochwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) DEC 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948, at 7:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28- 1942 to 12-11- 1948 and that I last saw him alive on 12-11- 1948.

Immediate cause of death Cerebral Thrombosis — Duration 3 days
Due to Arteriosclerotic — 1942
Cardio-vascular-renal
Due to disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melton C. Lang M. D.
Address 2117 Belair Rd Date signed 12-12-48

PLEASE WRITE PLAINLY, with unfading ink. Be sure that the information you give is correct and complete. Answer every question; if none, write "none" or "0" (zero). Be sure that the age is correct. Physicians: please write the causes of death clearly and legibly. Underlining the cause to which death should be charged statistically is especially important.

69395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G69395 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3703 Forest Pk. Ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Forest Pk. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BLANCHE LOUISE PRINCE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife *
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 29, 1881

8. AGE: Years	Months	Days	If less than one day
67	4	11	12 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business Instr. Vis. Nurs. Asso.

FATHER
12. Name Conrad Prince
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Caroline Smith
15. Birthplace Germany

16 (a) Informant Mr. Walter C. Hammond, Jr.
(b) Address 3703 Forest Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1948, at 8 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1947 to 12/10 1948 and that I last saw h[er] alive on 12/6 1948.

Immediate cause of death	Duration
Myocardial insufficiency	1 hr.
Due to Hypertension	1½ mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert A. Reiter
Address 3408 Windsor Ave Date signed M. 12 D. 16/48

VS 150

G69396

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G69396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2941 N. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2941 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAULINE E. COHN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 28, 1871

8. AGE: Years	Months	Days	If less than one day
77	0	12	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name M. G. Cohn
13. Birthplace Bremen, Germany

MOTHER
14. Maiden Name Emily Stoll
15. Birthplace Germany

16 (a) Informant Mr. J. Theodore Wolfe
(b) Address Gas & Elec. Co., Lexington Bldg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH dec. 10 1948 at 4 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1948 to dec. 10 1948, and that I last saw h alive on Nov. 9 1948.

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to Arteriosclerosis — Duration Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury?

23. Signature L. W. Saunders M. D.
Address 216 Goodale Rd. Balto. Md. Date signed Dec 13/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69397

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 937 Registered No. G69397

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Fort Howard (If outside city or town limits, write RURAL and give town)
(d) Street No. Veterans' Hospital (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHESTER CRAIG

3 (b) If veteran, name war 1st World War

3 (c) Social Security Account No.

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 6, 1887

8. AGE: Years 61 | Months 3 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Craig
13. Birthplace Bangor, Maine

MOTHER
14. Maiden Name Anna Luckner
15. Birthplace Taney Town, Md.

16 (a) Informant Mable A. Leimbach
(b) Address 525 N. Lyndhurst Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 12-14-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Avenue

18 (a) Funeral director Geo. H. Leimbach
(b) Address 525 N. Lyndhurst Street

19 (a) Date received DEC 13 1948 Registrar Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1948, at 7.15a.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
1. Myocardial degeneration
2. Chronic alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner
Date signed December 11, 1948

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G69398

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 W Fayette ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK ITLISHIS

3 (b) If veteran, name war No
3 (c) Social Security Account No. 217-01-8789

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 58 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ? Klishis
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Frank Klishis
(b) Address 2510 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Beloit Rd

18 (a) Funeral director Joseph Kasinskas
(b) Address 602 Washington Blvd

19 DEC 12 1948 (b) Huntingtown Williamsport, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11 1948, at 12.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1948 to 12-11 1948, and that I last saw h[illegible] alive on 12-11 1948.

Immediate cause of death: Myocardial infarction
Due to: Coronary thrombosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Goldenberg M. D.
Address University Hosp. Date signed 12-11-48

Physicians: please write the causes of death clearly and legibly. Cause of death which is the result of violence must be described so that the manner in which violence occurred is clear. Mode of dying, such as heart failure, asphyxia, etc., is not sufficient. Indefinite terms, such as senility, should be avoided. Where there is no physician in attendance, or where he does not sign the certificate, the undertaker should obtain the information as to the cause of death, and the certificate should be signed by the coroner. Deaths of children under one year of age should be carefully certified, and the exact cause of death stated. Even if the baby lived but a few hours, the cause of death is especially important.

VS 150

X

G69399

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 953 ✓

Registered No. G69399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. Montgomery Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** KATHERINE A. DIXON

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 26, 1894

8. AGE: Years	Months	Days	If less than one day
54	4	14 15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name William T. Dixon, Sr.
13. Birthplace Howard County, Md.

MOTHER
14. Maiden Name Amelia Gunther
15. Birthplace Ba ltimore, County, Md.

16 (a) Informant William T. Dixon, Sr.
(b) Address Montgomery Rd. Elkridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/48. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 DEC 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12.10 1948, at 6.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1948 to 12.10 1948, and that I last saw her alive on 12-10 1948.

Immediate cause of death Rheumatic heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Goldenheimer M. D.
Address University Hosp Date signed 12.12.48

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

X

669400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669400

PLEASE WRITE PLAINLY, WITH UNFADING INK. Employ undertaker to complete this certificate. Give information required on all lines, or state definitely that it cannot be obtained. Physicians: please write the causes of death clearly and legibly. Be sure that the age is correctly stated. Do not abbreviate. Write out the full name of the street and number, or other exact location, of residence. Do not report "Hospital" as residence unless the deceased had no home. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Earl Court Apts, St. Paul Sts. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Sweeney

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1870

8. AGE: Years	Months	Days	If less than one day
78	8	21	hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation Accountant, Retired
11. Industry or business

FATHER
12. Name Michael Sweeney
13. Birthplace Penna

MOTHER
14. Maiden Name Marcella Girtz
15. Birthplace Penna

16 (a) Informant Hazelton A. Joyce
(b) Address Earl Court Apts

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/13/48 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Pittsburgh Pa.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) [illegible] (b) Burial for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 1948, at 6:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1948, to Dec. 13 1948, and that I last saw h[illegible] alive on Dec. 12 1948.

Immediate cause of death Cerebral Thrombosis — Duration 4 days
Due to
Due to Arteriosclerosis — 3
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dewey Langdon M. D.
Address 400 N. Payson St. Date signed 12/13/48

VS 150

669401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57E

669401 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 Ellsworth St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Grandy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	married

6 (b) Name of husband or wife Mary Grandy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. & O. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1462 E. Preston St

19 (a) DEC 13 1948 (Date rec'd by registrar) (b) Funeral director Williams

VS 199

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1948, at 2 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Pulmonary Embolism

Due to Phlebothrombosis, Hepatic vein

Due to

Other Conditions Hepatoma Primary
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See Above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman Mellinkoff M. D.
Address Johns Hopkins Hosp Date signed 12-14-48

100 B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B.C. 48-24196 107 ✓ G63402 Registered No. 19447

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1447 Bendor Court.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (6)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1447 Bendor Court (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Patricia Ann Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 28, 1948

8. AGE: Years	Months	Days	If less than one day
0	1	14	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Anderson
13. Birthplace SC

MOTHER
14. Maiden Name Elizabeth Smith
15. Birthplace Baltimore Md.

16 (a) Informant Elizabeth Smith.
(b) Address 1447 Bendor Court.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. G. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1413 E. Preston St

19 (a) DEC 13 1948 (Date rec'd by registrar) Hunterstown Wilson

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1948 19 , at 5:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1948 to Dec 12 1948, and that I last saw her alive on Dec. 11 1948

Immediate cause of death Broncho-pneumonia — Duration 4 days.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Leighton
Address 501 Cherry Hill Rd. Date signed 12/12/48 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Items 1 to 19 must be answered in all cases. If unknown, or if the question is not applicable, state. Do not use dashes or leave blanks. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Please see that the information is complete and correct age is especially important.

VS 150

Med Exams Case 669403 Released to Hospital

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 669403

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 9
(d) Street No. 1708 N. Spring St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace NC (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name John H Brooks
13. Birthplace NC

MOTHER
14. Maiden Name Amelia Brooks
15. Birthplace NC

16 (a) Informant Marion Stewart
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus

18 (a) Funeral director Clayton Sanders
(b) Address 1412 E Preston St

19 (a) DEC 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1948, at 11 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 8 1948, to Dec. 8 1948, and that I last saw her alive on Dec. 8 1948.

Immediate cause of death	Duration
Myocardial infarction	
Due to Hypertensive cardio Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

CERTIFICATION APPROVED BY CHIEF MEDICAL EXAMINER

Date of operation
Major findings of operation: —
of autopsy: Pat. myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Hospital Date signed 12-7-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 153

To be Approved by Medical Examiner X

69404

391862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. 69404

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 Penrose, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard P. Owens

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 220-030876

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sophie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-17-75

8. AGE: Years 73 | Months 7 | Days 5 | If less than one day: hr. min.

9. Birthplace Md. Baltimore (Town, county, and state)

10. Usual Occupation Watchman Retired

11. Industry or business

FATHER 12. Name Richard Owens
13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen Thompson
15. Birthplace England

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Coyan & Son
(b) Address 901-03 Fallsway St.

19 DEC 13 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1948, at 5-45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9- 1948 to 12-12- 1948 and that I last saw him alive on 12-12- 1948.

Immediate cause of death: Cardiac failure

Due to: Hypertensive arteriosclerotic cardio-vascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Watkins M. D. DEC 1948

Address Johns Hopkins Hospital Date signed DEC 12 1948

VS 150

X

Physicians: please write the causes of death clearly and legibly. Information required in items 1 to 19 is especially important. Be sure that every item is correctly answered.

69405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69405

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3431 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM E. STRITCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1898

8. AGE: Years	Months	Days	If less than one day
50	5	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Free Lancer

FATHER
12. Name William J. Stritch
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna M. Grace
15. Birthplace Baltimore Co., Md.

16 (a) Informant: Mr. Daniel J. Stritch
(b) Address 6 Upland Rd., Roland Pk.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-48 (month) (day) (year) Apt.

(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) DEC 13 1948 (Date received by Registrar) (b) Hunting for Williams Mc

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1948, at 4.00a. M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest & Abdomen
Evisceration

Due to Evisceration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-13-48 at approx. 2.30 a. M.
(b) Where did injury occur? Wash. Blvd. south Caton A
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? yes
(d) Means of injury pedestrian struck by tractor-trailer truck

23. Signature Earl H. Light M.D.
Medical Examiner

Date signed December 13, 1948

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G69406

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5800 Clark's Hill
(c) Hospital or institution:

27-12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5800 Clark's Hill (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Olden Morningstar

3 (b) If veteran, name war ----

3 (c) Social Security Account No. 213-01-0536

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Rosie A. Morningstar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1887

8. AGE: Years	Months	Days	If less than one day
61	11	10	hr. min.

9. Birthplace Baltimore Co., Maryland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John Samuel Morningstar
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise ---
15. Birthplace Maryland

16 (a) Informant John S. Morningstar
(b) Address 5800 Clark's Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) DEC 13 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1948, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Dec 11 1948, and that I last saw him alive on Dec 1 1948

Immediate cause of death Myocardial failure, acute

Due to Coronary Arteriosclerosis arterial Hypertension

Due to

Other Conditions (OVER)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
10 yrs -
10 yrs -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Wardley Jr. M. D.
Address 3900 Alameda Ave Date signed 12/15/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. G69407

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 844 W. 36th Street
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 844 W. 36th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Helen Grace Cox

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 212-22-7416

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife William E. Cox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 23, 1895

8. AGE: Years	Months	Days	If less than one day
53	2	19	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Social Security
11. Industry or business

FATHER
12. Name Charles H. Walter
13. Birthplace Maryland

MOTHER
14. Maiden Name Grace E. Cox
15. Birthplace Maryland

16 (a) Informant Mrs. Harry J. Lehr
(b) Address 844 W. 36th Street

17 (a) Burial (b) Date thereof Dec. 14, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 DEC 13 1948 (Huntington Avenue, Md)
(Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH December 12, 1948, at 5.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Dec 1948, to 12 Dec 1948, and that I last saw her alive on 12 Dec 1948.

Immediate cause of death	Duration
Heart failure	
Due to Hypostatic +	
Due to Squamous cell carcinoma of throat	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 13 Sept 48

Major findings of operation: Carcinoma of throat + spread to neck

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M. D.
Address 846 W. 36th St Date signed 13 Dec 48

+

VS 150

GH. G69108 125134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 2-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2033 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dela Brehm

3 (b) If veteran, name war	3 (c) Social Security Account No.
c	c

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Harry Brehm.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 24 1894.

8. AGE: Years	Months	Days	If less than one day
54 ?	1	17	hr. min.

9. Birthplace MD. Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Mc. Cormick
13. Birthplace ? Arundel County Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13 1948 (month) (day) (year)
(c) Cemetery or crematory St. Matthias
Location Odenwald Rd.

18 (a) Funeral director Wendell J. Hagel
(b) Address 812 S. Highland Ave

DEC (a) 13 1948 (date rec'd by registrar) (b)

Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12- 10- 1948, at 2 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 6-1948, to 12- 10-1948, and that I last saw her alive on 12- 10- 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Hypertensive Arteriosclerotic Cardiovascular Disease.	
Due to	
Other Conditions Congenital syphilis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Ordered

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vickers Jr. M.D.
Address Balto City Hosp. Date signed Dec 14 48

4 copy

G69409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164 E

Registered No. G69409

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2543 North Howard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREEMAN EPPS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife JANIE EPPS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/1907

8. AGE: Years	Months	Days	If less than one day
41	8	22	hr. min.

9. Birthplace VIRGINIA
(Town, county, and state)

10. Usual Occupation CITY EMPLOYEE

11. Industry or business

FATHER
12. Name SAM EPPS
13. Birthplace Virginia

MOTHER
14. Maiden Name CARRIE PALMER
15. Birthplace VIRGINIA

16 (a) Informant Provident Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St

19 (a) Date received by registrar DEC 1 3 1948 (b) Huntington Williams, Jr. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8/48 19 , at 3:55 AM

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured Ribs, Contusion Chest

Due to

Other Conditions Lobar pneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/8/48 at 3 A. M.
(b) Where did injury occur? 1514 Division Street
(c) Did injury occur at home, on farm, industrial place, in public place? Provident Hospital (Specify) (Time at work?) No
(d) Means of injury Jumped from Window

23. Signature John R. Walsh, M.D.
Medical Examiner.
Date signed 12/8/48

G69410 ✓ G69410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ST JOSEPH'S HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yr's

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 HARFORD COURT (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM H. VIVIAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife Annie Vivian
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
73 73			hr. min.

9. Birthplace Wilkesbarre Pennsylvania (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER 12. Name Robert Vivian
13. Birthplace England

MOTHER 14. Maiden Name Sally Bidlich
15 Birthplace England

16 (a) Informant Mrs. Samuel Cooke
(b) Address 3308 N Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director Loring Bryan
(b) Address 5005 Park Heights Ave

19 (a) (Local registrar) Huntington Williams M.D. Registrar

DEC 13 1948

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 11 19 48, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV. 25 48 Dec. 11 19 48, and that I last saw him alive on Dec 11 19 48

Immediate cause of death	Duration
Pneumonia(aspiration)	
Due to aspiration of vomitus	
Due to carcinoma of [redacted] larynx	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Dec 3, 1948 Dec 1, 1948

Major findings of operation: Ca of Larynx inoperable

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene F. Kelly M. D.
Address ST JOSEPH'S HOSPITAL Date signed DEC 11 19

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69411

BC.48-15640

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

182a

G69411 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 North Pine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORIS R. CROSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1948

8. AGE: Years	Months	Days	If less than one day
	4½	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation baby

11. Industry or business

FATHER
12. Name John Cross
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Ruffin
15. Birthplace Maryland

16 (a) Informant Sarah Cross
(b) Address 313 N. Pine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Enid G. Nelson

18 (a) Funeral director George G. Nelson
(b) Address 1343 Presstman St

19 (a) DEC 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1948, at 4.30a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Mechanical Suffocation

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 4/2
(a) Date of injury 12-11-48 at approx. 3.00 a.M.
(b) Where did injury occur? 313 N. Pine St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury mechanical suffocation by bedclothes

23. Signature Earl R. Zeigler, M.D. Medical Examiner.
Date signed December 11, 1948

Please answer all questions. Physicians: please write the causes of death clearly and legibly. Omission or incorrect age is especially important.

VS 151

X

G69412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G69412 Registered No. 940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not abbreviate. Give full name of deceased. If not in hospital or institution, give residence. Do not use words "same," "do," etc. Answer all questions. Underline the correct answer. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 105 E. Lafayette Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 105 E. Lafayette Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry H. Hoffmeister

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-03-6521

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower

6 (b) Name of husband or wife Fannie A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 16, 1887

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61	7	23		

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business American Store

FATHER
12. Name Henry Hoffmeister
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Michael
15. Birthplace Md

16 (a) Informant Lee Hoffmeister

(b) Address 3619 Chesterfield Ave

17 (a) Burial (b) Date thereof Dec. 13/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville — Md

18 (a) Funeral director Harry H. Mitchell

(b) Address 1601 E. Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Interment or Removal, Washington Memorial Park

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/9/48 19 , at 1116 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1948 to Dec 9 1948 and that I last saw him alive on Dec 9 1948

Immediate cause of death	Duration
Acute pulmonary edema	15 Min
Due to Coronary thrombosis	1 week
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Joseph S. Gans M. D.

Address 107 Eutaw Pl Date signed Dec

VS 150

X 1/4 1948

G69413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G69413 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County White Stone
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kellum, Lydia

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife deceased. John Edwin. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 14 1885

8. AGE: Years	Months	Days	If less than one day
63	1	29	hr. min.

9. Birthplace White Stone, Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin Seawell, dec.
13. Birthplace Virginia

MOTHER
14. Maiden Name Georgiana West, dec
15. Birthplace Virginia

16 (a) Informant Harry T. Kellum
(b) Address 3621 Sussex Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Druid Ridge Pk.

18 (a) Funeral director Harry H. Fitzke
Address 4101 Edmondson Ave.

19 (a) DEC 13 1948 (Date rec'd by Registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12 1948, at 7 23 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1948 to 12-12 1948 and that I last saw her alive on 6 23-48 1948.

Immediate cause of death Cardiorespiratory failure — Duration

Due to Hypertensive H. D.

Due to Gen. arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Lawrence L. Finkelstein M. D.
Address Franklin Sq. Hos. Date signed 12/12/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G69414

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1933 Breitwert Ave.
(c) Hospital or institution:

25

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 Breitwert Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY SONNENLEITER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary A. Sonnenleiter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 12, 1866

8. AGE: Years	Months	Days	If less than one day
82	9	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Variety Molder, retired
11. Industry or business

FATHER
12. Name Michael Sonnenleiter
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Horlacher
15. Birthplace Germany

16 (a) Informant Mr. Percy Sonnenleiter
(b) Address 1933 Breitwert Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) DEC 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1948 at 1:10a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1948 to Dec. 11 1948, and that I last saw him alive on Dec 9 1948.

Immediate cause of death Cerebral Anemia — Duration

Due to Cerebral Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Hope Jr.
Address 2411 Washington Blvd Date signed 12/11/48 M D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS :50

69415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G69415

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14-
(c) Hospital or institution: West Baltimore Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 S. Arlington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE F. COSTELLO SAGLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Minnie E. Sagle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1863

8. AGE: Years	Months	Days	If less than one day
85	7	28	hr. min.

9. Birthplace Harpers Ferry, W. Va.
(Town, county, and state)
10. Usual Occupation Boilermaker (retired)
11. Industry or business B. & O. R. R.

FATHER
12. Name Nathan Sagle
13. Birthplace Mass.

MOTHER
14. Maiden Name Storm
15. Birthplace Md.

16 (a) Informant Mr. A. L. Sagle
(b) Address 113 B Osborne Ave., Catonsville

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/15/48 (month) (day) (year)
(c) Cemetery or crematory Harpers Ferry Cem.
Location Harpers Ferry, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 13 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1948, at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1948 to Dec 12 1948, and that I last saw h[illegible] alive on Dec 12 1948.

Immediate cause of death	Duration
Respiratory circulatory failure	
Due to Arteriosclerotic heart disease	
Due to Generalized arteriosclerosis	
Other Conditions Bilateral inguinal hernia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address West Balt Gen'l Date signed

Hosp x Dec 12, 1948

Please write plainly. Physicians: please write the causes of death clearly and legibly. Statement of cause of death, and correct age is especially important.

G69416

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G69416

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 13
(e) Length of stay in Baltimore (yrs., mos., or days): 6 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2420 Lakeview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Harry H Rash

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 16,1910

8. AGE: Years: 38 Months: 5 Days: 27 If less than one day: hr. min.

9. Birthplace: Philadelphia Pa (Town, county, and state)

10. Usual Occupation:

11. Industry or business: U. S. Goverment

FATHER
12. Name: Morris Rash
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rose Maranoff
15. Birthplace: Russia

16 (a) Informant: Mrs Rose Rash
(b) Address: 2420 Lakeview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 15, 1948 (month) (day) (year)
(c) Cemetery or crematory: Philadelphia Pa
Location: Phila Pa

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19. DEC 13 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/13 1948, at 6 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1948, to 12/13 1948, and that I last saw him alive on 12/13 1948.

Immediate cause of death: Myocardial Infarction — Duration:

Due to: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Myocardial infarction Coronary occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Marjorie Oneam, M. D.
M. D.
Address: Sinai Hosp. Baltimore Date signed: 12/13/48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 190

X

69417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 69417

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6407 SEFTON AVE. (14)
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 5 —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6407 SEFTON Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK W. PRZYBYLSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 188-01-2683

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7-1887

8. AGE: Years	Months	Days	If less than one day
61	2	6	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Walter Przybylski
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria
15. Birthplace Poland

16 (a) Informant Mrs. Mary F. Przybylski
(b) Address 6407 Sefton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Pa.

18 (a) Funeral director Leonard J. Luck
(b) Address 5[illegible] Stafford Rd.

19 (a) DEC 15 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1948, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1948 to Dec. 13 1948 and that I last saw him alive on Dec. 13 1948.

	Duration
Immediate cause of death: Myocardial degeneration	2 yrs.
Due to: (a) Pulmonary emphysema	10 yrs.
(b) Chronic Bronchitis	10 yrs.
Due to:	
Other Conditions: Asthma	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W Dacken
Address 633 Belair Ave (c) Date signed 12/13/48 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

NAGEL

69418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered 69418

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynard & Dudeland
(c) Hospital or institution:
West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2256 Cecil Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Finegel 48-27018

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Edward W Nagel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 21-1915

8. AGE: Years	Months	Days	If less than one day
33	7	22	hr. min.

9. Birthplace Cambridge Maryland
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Sheldon Fothwell
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Twilley
15. Birthplace Md.

16 (a) Informant Mrs. Edward Nagel
(b) Address 2256 Cecil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Balto

18 (a) Funeral director J. J. Kuck
(b) Address 5305 Stafford Rd.

19 (a) DEC 13 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 19 48 at 2:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 19 48 to 12/12 19 48
and that I last saw her alive on 12/12 19 48

Immediate cause of death Respiratory arrest

Due to Cerebral metastases

Due to Carcinoma of breast

Other Conditions Pregnancy - 4½ mos

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard A Blumberg M.D.
Address 1501 Eutaw Place Date signed 12/13/48

Please write plainly. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

VS 150

X

G69419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 94a

Registered No. G69419

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4600 Liberty Heights Ave
(c) Hospital or institution:
In Automobile
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) D.O.A.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town New Windsor (RFD 1)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sams Creek Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME PERCY C. PUMPHREY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife May L. Pumphrey (Nee Waters) 6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1899

8. AGE: Years	Months	Days	If less than one day
49	3	24	hr. min.

9. Birthplace Anne Arundel County, Md.
(Town, county, and state)
10. Usual Occupation Mill Hand (Retired)
11. Industry or business U.S. Coast Guard, Curtis Bay

FATHER
12. Name John Pumphrey
13. Birthplace Anne Arundel County, Md.

MOTHER
14. Maiden Name Louise Stinchcomb
15. Birthplace Anne Arundel County, Md.

16 (a) Informant Mrs. May L. Pumphrey
(b) Address New Windsor (RFD 1)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14, 48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W Brighton
(b) Address Glen Burnie, Md. Huntington Williams, M.D.

19 (a) DEC 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948, at 8.55 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Lubricki M.D.
Medical Examiner.
Date signed 12/12/48

VS 181

069-120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 069-120

Please write plainly. Physicians: please write the causes of death clearly and legibly. Give correct age in each case where it is especially important.

1. PLACE OF DEATH: D.of.H
(a) Baltimore City, Maryland
(b) Street address 1218 Wilcox St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 Wilcox St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stephen Kreusinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Barbara Kreusinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1876

8. AGE: Years	Months	Days	If less than one day
72	7	16	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Frabk Kreusinger
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea O
15. Birthplace Germany

16 (a) Informant Mrs Charles Kraft
(b) Address 818 Cator Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Balt St

19 (a) (Date received) DEC 13 1948 (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12 1948, at 7:30 M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic
C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Tubanbe M.D.
Medical Examiner.
Date signed 12/13/48

9421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

669421 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: Mercy Hospital 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3340 Old York Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. CHRISTINA FITZPATRICK

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife William Fitzpatrick
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Feb 6, 1877

8. AGE: Years	Months	Days	If less than one day
71	10	5	hr. min.

9. Birthplace Baltimore / Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Home

FATHER
12. Name Philip Ness
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary Rooney
15. Birthplace Ireland.

16 (a) Informant Wm. A. Fitzpatrick
(b) Address 3547 Greenmount Ave

17 (a) Burial (b) Date thereof 12 15 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John E. Moran
(b) Address 3000 E. Baltimore St

19 (a) DEC 18 1948 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1948, at 12 19 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1948 to Dec 11 1948, and that I last saw h alive on Dec 11 1948

Immediate cause of death	Duration
Generalized Cachexia	4 mos.
Due to CI Obstruction	4 mos.
Due to Ca Stomach	—
Ca Bowel - metastatic implant	—
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Basalic Ca
C generalized metastasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. M. Smelser M. D.
Address Mercy Hosp Date signed 12/11/48.

X

C69422

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. C69422

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4711 Delaware Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4711 Delaware Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia E. Harrigan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1872

8. AGE: Years 76 | Months 5 4 | Days 22 | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Harrigan
13. Birthplace Ireland

MOTHER
14. Maiden Name Hanna Barr
15. Birthplace Ireland

16 (a) Informant Sylvester Kusterer
(b) Address 4711 Delaware Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3006 E. Baltimore St.

19 (a) DEC 13 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9 1948 to Dec 11 1948. and that I last saw h alive on Dec. 10 1948.

Immediate cause of death
Cerebral apoplexy
with Coma
Due to
Arteriosclerosis.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W E Steadle M.D.
Address 914 W. Mon St. Date signed 12/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

G69423

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 937

Registered No. G69423

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged & Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Humphrey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W.

6 (b) Name of husband or wife Mary Wield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1871

8. AGE: Years	Months	Days	If less than one day
77 76	2	-	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Humphrey
13. Birthplace

MOTHER
14. Maiden Name Catherine Clark
15. Birthplace

16 (a) Informant Gill Hall 1631 E North Ave
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14. 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Berydale St Huntington Station, Md.

19 DEC 13 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1948, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1948 to Dec 11 1948, and that I last saw him alive on Dec 11 1948.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Chronic Myocarditis	3 yrs
Due to	5 yrs
Other Conditions Arteio Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 12/12/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

669424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 669424

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, whether married, widowed, or divorced, and date of birth. Fill in all items. Underline the cause to which death should be charged statistically. Do not abbreviate. Use no ditto marks. Be sure that the age, occupation, and residence are given for each person and that the cause of death is entered in such terms as to show the disease, the contributory causes, if any, and the principal cause of death. Indefinite and unsatisfactory terms, such as "debility," "old age," "exhaustion," "cancer," "tumor," should be avoided. Where there is a doubt as to the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 N. Milton Ave
(c) Hospital or institution: West Balto General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 N. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Dr. August P ~~Christ~~ Crist

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Sarah Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 30 - 1884

8. AGE: Years	Months	Days	If less than one day
64	4	12	hrs. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Dentist

11. Industry or business

FATHER
12. Name Charles F. Christ
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Friedenstein
15. Birthplace Balto Md.

16 (a) Informant Sarah Bessie Crist
(b) Address 1433 - N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location MD.

18 (a) Funeral director Edelworth Armacost
(b) Address 3946 Liberty Heights Ave

19 DEC 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1948, at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1948 to Dec 12 1948, and that I last saw h[illegible] alive on Dec 12 1948.

Immediate cause of death Respiratory circulatory arrest.

Due to Arterio-sclerotic heart disease

~~Due to~~ Generalized carcinoma - primary site unknown

Other Conditions Gouty arthritis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Lueken M.D.
Address West Balt Gen Hosp Date signed Dec 12, 1948

VS 150

69425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G69425

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 321 South Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANTHONY O'TOOLE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
white	male	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (unknown) May 22, 1901

8. AGE: Years	Months	Days	If less than one day
47 (48)	6	20	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Anthony O'Toole
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Margaret Holmes
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Cecelia Emmel
(b) Address 321 South Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16-48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location BALTIMORE MD.

18 (a) Funeral director John A. Grebliauckas, Jr.
(b) Address 423 S. Paca Street

19 (a) DEC 13 1948 (b) Carrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1948, at 2.05 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Royer M.D. Medical Examiner.
Date signed December 11, 1948

PLEASE WRITE PLAINLY, with unfading ink. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

669426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 669426

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Montpelier St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Montpelier St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kozlowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Kozlowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Cabinet Maker.
11. Industry or business

FATHER
12. Name ?
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Roman Kozlowski
(b) Address 1701 Montpelier St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarzewski
(b) Address 1930 Eastern Ave.

19 (a) DEC 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948, at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1948 to Dec 11 1948 and that I last saw h[illegible] alive on Dec 10 1948.

Immediate cause of death — Duration
Cerebral Vascular Disease — 3 yr
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed Dec 13 48

VS 150

G69427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69427

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 267 N. Exeter St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-2
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 267 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife Glenn Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1880

8. AGE: Years	Months	Days	If less than one day hr.	min.
68	4	9		

9. Birthplace Greenbay Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter Neal
13. Birthplace Green Bay, Va.

MOTHER
14. Maiden Name Mary —
15. Birthplace Green Bay, Va.

16 (a) Informant George Jones
(b) Address 267 N. Exeter St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 16/48 (month) (day) (year)

(c) Cemetery or crematory
Location Farmville Va.

18 (a) Funeral director Geo R.A. Elliott & Son
(b) Address 129 N. Carolyn St.

19 (a) DEC 13 1948 (b) Huntington-Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1948, at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1948, to Dec 12 1948, and that I last saw her alive on Dec 12 1948.

	Duration
Immediate cause of death: Cerebral Hemorrhage	4 days
Due to: Hypertension Cardio-Vascular disease.	4 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R B Livingston M. D.
Address 501 Cherry Hill Rd Date signed 12-13-48

VS 150

069428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. 069428

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 609 Reisterstown Rd

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11- 62 ds

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 12 W. Read St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mary R. Fink

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Charles Fink

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17- 1868

8. AGE: Years	Months	Days	If less than one day
79	11	24	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER

12. Name Charles Byrne

13. Birthplace Maryland

MOTHER

14. Maiden Name Mary E Cunning

15. Birthplace Maryland

16 (a) Informant Mrs. Clara Hughes Mother

(b) Address 12 W. Read St

17 (a) Removal (b) Date thereof 12/14/48 (month) (day) (year)

(c) Cemetery or crematory

Location Phoenixville, Pa

18 (a) Funeral director Chas. F. Evans & Son

(b) Address 118 W. Mt Royal Ave

19 (a) DEC 13 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1948 to Dec 11 1948.

and that I last saw her alive on Dec 11 1948.

Immediate cause of death	Duration
Cerebral Embolism &	3 days
Thrombosis of Rt. Femoral art	3 days
Due to Auricular fibrillation	?
and arteriosclerotic Hrt. Dis	
Due to Arteriosclerosis	
Other Conditions Cardiac decomp. &	?
Pneumonia & Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jonas H. Cohen M. D.

Address 6901 Park Heights Ave Date signed 12/13/48

VS 150

X

G69429

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G69429

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson Sts.
(c) Hospital or institution: Bon Secours Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 60 S Kossuth St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William H. Cunningham

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-26-6962

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, ~~widowed, or~~ divorced: Married

6 (b) Name of husband or wife: Mrs. Anna Cunningham

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Aug 26-1889

8. AGE: Years 59 | Months 3 | Days 15 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Saleem-Manufacturer

11. Industry or business Owner of Business

FATHER
12. Name John D. Cunningham
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah V. Scarf
15. Birthplace Maryland.

16 (a) Informant Mrs. Anna M. Cunningham
(b) Address 60 S. Kossuth St.

17 (a) Buried L. (Burial, cremation, or removal) (b) Date thereof Dec. 14-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore - Md.

18 (a) Funeral director F. B. Wippert & Son
(b) Address 300 Eutaw Place

19 (a) DEC 13 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 1948, at 7:46 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1948 to 12/11 1948, and that I last saw him alive on 12/10 1948.

Immediate cause of death	Duration
Congestive Heart failure	
Uraemia (oliguria)	
Due to Arteriosclerosis	
Due to	
Other Conditions Hydrocele - decompensation Cardiac Paychosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William S. Womack
Address Bon Secours Hosp. Date signed 12/11/48 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G69430

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G69430

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2432 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Agnes J. Stocker " Agnes J. Stocker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Charles J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19 1895

8. AGE: Years	Months	Days	If less than one day
53	4	22.	hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business At Home

FATHER
12. Name Louis Haigis
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary D. Wunder
15. Birthplace Lancaster Pa.

16 (a) Informant Charles J. Stocker
(b) Address 2432 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore - Md

18 (a) Funeral director H. B. Hilgart & Son
(b) Address 300 Eutaw Place 17

19 (a) DEC 18 1948 (Date rec'd by registrar) (b) Huntington Hilgart, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11/48 19 , at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9/48 19 to 12/11/48 , and that I last saw h alive on 12/11/48 19 .

Immediate cause of death	Duration
Pulm. Edema	
Due to CPC	
Due to Subarachnoid Hem.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lee N. Kastan M. D.
Address Sinai Date signed 12/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

669431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 101 days
(e) Length of stay in Baltimore (yrs., mos., or days): 101 days ?

2. USUAL RESIDENCE OF DECEASED:
(a) State: Texas (b) County:
(c) City or town: Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 207 W. Tabor St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: DAVID ALBIN TAXEN

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: 461-28-6068

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Marion Llewelyn
6 (c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Aug. 16, 1888

8. AGE: Years	Months	Days	If less than one day
60	3	28	hr. min.

9. Birthplace: Sweden (Town, county, and state)
10. Usual Occupation: Pumpman
11. Industry or business: Seafarer

FATHER
12. Name: Carl Taxen
13. Birthplace: Sweden

MOTHER
14. Maiden Name: Matilda Kristina Tsfhors
15. Birthplace: Sweden

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof: Dec 13-48 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Balto - Md

18 (a) Funeral director: Ellsworth Chapel
(b) Address: 3411 Liberty Heights

19 (a) DEC 13 1948 Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 13 1948, at 2:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1948 to Dec. 13 1948, and that I last saw him alive on Dec. 13 1948.

Immediate cause of death	Duration
Carcinoma of the lung with metastasis to brain	Unknown
Due to	
Due to	
Other Conditions: Bronchopneumonia	Unknown

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed: 12/13/48 M. D.

VS 180

G69432 #28944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

139a

Registered No. G69432

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 N. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Reed -

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No.

Sex: Female Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John -
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr) 7-6-19

8. AGE: Years 29 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Va. - (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wilbert Sinclair
13. Birthplace Va. -

MOTHER 14. Maiden Name Cora Butler
15. Birthplace Va

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/48 (month) (day) (year)
(c) Cemetery or crematory Rocky Mt.
Location Rocky Mt. Va.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pressman St. Balto. Md. 17

19 (a) DEC 13 1948 (Date rec'd by Registrar) Huntington Williams M.D.
(b)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11th 1948 at 12:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1948 to Dec. 11 1948 and that I last saw her alive on Dec. 11 1948

Immediate cause of death: Uremia — Duration: 2 wks
Pelvic Abscess
Due to: ? Lupus Erythematosus — 5 yrs
Lupus-Erythematosus

Other Conditions: Peritonitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Peritonitis
of autopsy: Peritonitis, Abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard S Ross M.D.
Address Johns Hopkins Date signed 12/12/48

669433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a ✓

Registered No. 669433

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 St. Georges Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 ST. GEORGES RD.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Galt Fitzgerald

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida R. O. Noon
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) FEB. 15, 1878

8. AGE: Years	Months	Days	If less than one day
70	9	15	hr. min.

9. Birthplace Paris, France
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Delano S Fitzgerald
13. Birthplace Maryland

MOTHER 14. Maiden Name Sara Edwards Jackson
15. Birthplace Dublin Ireland

16 (a) Informant Delano J Fitzgerald
(b) Address 203 Taplow Rd

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12 14 '48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTO.

18 (a) Funeral director H. W. JENKINS & SONS CO.
(b) Address 4905 York Rd Phuntington for Williamsport, Md

19 (a) DEC 13 1948 (b) (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1931 to Dec 1948
and that I last saw h alive on Oct 1948

Immediate cause of death	Duration
Acute Coronary Thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Daniel J Fitzgerald M. D.
Address 8047 St Paul ST Date signed 12/13/48

Please write plainly with ink or indelible pencil. Physicians: please write the causes of death clearly and legibly. Please see that age is correct. Information as to age is especially important.

VS 150

3c97 S: 1 AVL

G69434 BALTIMORE CITY HEALTH DEPARTMENT ✓ G69434
CERTIFICATE OF DEATH 94a
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski Sts
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 S. Caton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Theresa Schuman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1874

8. AGE: Years	Months	Days	If less than one day
74	1	25	27 hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Martin Vetter
13. Birthplace New Jersey

MOTHER
14. Maiden Name not known.
15. Birthplace

16 (a) Informant Edward F Farrell
(b) Address 1405 Caton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48 (month) (day) (year)
(c) Cemetery or crematory
Location Trenton, New Jersey

18 (a) Funeral director George H. Fahley
(b) Address Fulton Ave & Fayette St.

DEC 13 1948 (Date rec'd by registrar) Huntington Williams Mfg Co

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1948, at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1948 to Dec 13 1948 and that I last saw her alive on Dec 12 1948.

Immediate cause of death	Duration
Heart Failure	
Due to Coronary sclerosis	
Due to Involved arteriosclerosis	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature D Schuehler MD
Address Bon Secours Hosp. Date signed M. 12 D. 13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Give full name of deceased, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

69435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 637

G69435
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered; if none, so state. Do not use abbreviations. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Holbrook St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mollie Martin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe.	White	Widow

6 (b) Name of husband ~~or wife~~ Chas E. Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) January, 1855

8. AGE: Years	Months	Days	If less than one day
93	11	12	hr. min.

9. Birthplace Balto. Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ely Skipper
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sadie (Unknown)
15 Birthplace (Balto. Md.)

16 (a) Informant Mrs. Nellie Gillard
(b) Address 1824 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Marys
Location (Hamilton) Balto. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 127 St. Paul St.

19 (b) DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 1948 at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1948 to 12/13/ 1948 and that I last saw her alive on 12/13/ 1948.

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Hypertensive Arteria Sclerotic Heart Disease	
Due to	
Other Conditions Diffuse Adenoma. Thyroid. Tracheal Obstruction (Include pregnancy within 3 months of death)	

Date of operation 12/2/48
Major findings of operation: Tumor of Thyroid & Isth. (Tracheotomy)
of autopsy: Refused.

PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John T. Everett M. D.
Address St. Joseph Hosp. Date signed 12/13/48

VS 150

X

9436 BALTIMORE CITY HEALTH DEPARTMENT G69436

CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 2 13
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Edward Apts. Whitelock & Brookfield (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Jere T. Oppenheim

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Helen
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1863 Jan. 11

8. AGE: Years	Months	Days	If less than one day
85	11	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business —

FATHER
12. Name Abraham Oppenheim
13. Birthplace Germany

MOTHER
14. Maiden Name Henriette Abraham
15. Birthplace Germany

16 (a) Informant John Maurice R. Oppenheim
(b) Address Edward Apts. Whitelock & Brookfield

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-48 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Belair Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eutaw Place

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12 1948 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1948 to 12-12 1948, and that I last saw h[illegible] alive on 12-12 1948.

Immediate cause of death	Duration
Cardio-respiratory collapse	[illegible] days
Due to Arteriosclerotic heart Disease	6-7 yrs
Due to Bronchopneumonia	6 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Smith Jr. M.D.
Address Union Memorial Hosp. Balto. 18, Md. Date signed 12/12/48

VS 190

X

PLEASE WRITE CLEARLY with pen and ink. Physicians: please write the causes of death clearly and legibly. Be sure that the information given in items 20 to 22 is complete and correct age is especially important.

G69437

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G69437

CERTIFICATE OF DEATH

B.C. 48-27063 160a

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, and correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2219 Callow Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rottenberg, Baby girl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/12/48

8. AGE: Years	Months	Days	If less than one day
			4 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER — 12. Name Ratte Harry Rottenberg

13. Birthplace Hungary

MOTHER — 14. Maiden Name Beverly

15. Birthplace Hungary

16 (a) Informant Ratte Harry Rottenberg

(b) Address 2219 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Nehrgo

18 (a) Funeral director Jack Rewz Inc

(b) Address 2106 Eutaw Place

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 1948 at 9:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13, 1948 to Dec. 13, 1948. and that I last saw her alive on Dec. 13, 1948.

Immediate cause of death: Subarachnoid hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert J. Weiss M. D.

Address Sinai Hospital Date signed 12/13/48

VS 150

X

669138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

301

669138 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Cloverdale Rd.
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
3
(d) Street No. 1212 Cloverdale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LILLIE BELL JOE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Child Sitter

11. Industry or business

FATHER
12. Name ? Joe
13. Birthplace S.C.

MOTHER
14. Maiden Name ?
15. Birthplace S.C.

16 (a) Informant Henry White
(b) Address 1221 Cloverdale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director A. HALSTEAD
(b) Address 918 Druid Hill Ave.

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1948, at 10:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Lobar Pneumonia &
Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Kruger M.D. Medical Examiner.
Date signed 12/11/48

669139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669139

HQ-02579

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

17

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 Shields Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Vada D. McCoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 16, 1948

8. AGE: Years	Months	Days	If less than one day
	1	26	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Hubert McCoy
13. Birthplace North Carolina

MOTHER
14. Maiden Name Beatrice Bailey
15. Birthplace Maryland

16 (a) Informant Hubert McCoy
(b) Address 1131 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Avenue

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1948, at 10:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D. Medical Examiner
Date signed December 13, 1948

VS 181

69440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

69440 Registered No.

PLEASE WRITE PLAINLY with pen or indelible pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hosp.
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 N Paulk #2
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dolly Mc Griffith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1869

8. AGE: Years	Months	Days	If less than one day
79	2	21	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Balto City School Board - Ret.

11. Industry or business Teacher

FATHER
12. Name — James L. Griffith
13. Birthplace Md.

MOTHER
14. Maiden Name — Maria Logan
15. Birthplace Md.

16 (a) Informant Mrs. Hettie A. Watson
(b) Address 727 E. 23rd. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave. Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw place

19 (a) DEC 14 1948 (Date rec'd by local reg.) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1948, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1948 to 12-12 1948, and that I last saw her alive on 12-12 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardio-vascular disease	
Due to	
Other Conditions Arterial Sclerosis Heart Failure	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be changed statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Buchanan M.D.
M. D.

Address Mercy Hosp. Date signed 12-12-48

VS 150

937

69441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G69441

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Cambridge Arms Aprs.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2 Cambridge Arms Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Pauline Hamill Kelsey

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Dr. Harry E. Kelsey
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 22, 1877

8. AGE: Years: 71 | Months: 7 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business:

FATHER
12. Name: Geo. W. Hamill
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Blanche Grove
15. Birthplace: Balto. Md.

16 (a) Informant: Rosalie H. Mundy
(b) Address: Cambridge Arms Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn, Md.

18 (a) Funeral director: John O. Mitchell & Sons Inc.
(b) Address: 1900 Eutaw Place

19 (a) DEC 14 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 12, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1940 to Dec. 12 1948, and that I last saw h er alive on Dec. 12 1948.

Immediate cause of death: Cardiac decompensation — Duration: 6 months

Due to: Chronic rheumatic endocarditis with mitral stenosis — many years

Due to:

Other Conditions: Auricular fibrillation → 1938
Hemiplegia, left, from embolism 1943
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John Tilden Howard M. D.
Address: 12 E. Eager St. Date signed: Dec. 13, '48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 56c

Registered No. 659142

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1368 Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME McNair, Mamie

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 26, 1923

8. AGE: Years	Months	Days	If less than one day: hr.	min.
25 yrs	6	15		

9. Birthplace Scotland County N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Buddie Thomas
13. Birthplace N.C.

MOTHER
14. Maiden Name Minnie Smith
15. Birthplace N.C.

16 (a) Informant Eleise Graves
(b) Address 1368 Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48 (month) (day) (year)
(c) Cemetery or crematory Patuxent, N.C. Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 1948, at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12 1948 to 12/11 1948 and that I last saw her alive on 12/11 1948.

Immediate cause of death Respiratory Asphyxia — Duration

Due to Superior Anterior Mediastinal Tumor

Due to Aneurysm of arch of aorta

Other Conditions Fibroadenome right breast - removed (Include pregnancy within 3 months of death)

Date of operation 11/27/48

Major findings of operation: Fibroadenoma right breast

of autopsy: Aneurysm of aorta

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr Marcus W. Moore Sr M.D.
Address Provident Hospital Date signed 12/11/48

VS 159

669443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77c

Registered No. 669443

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DO A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Canal Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARNETT HEATH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Junk Man

11. Industry or business U N K N O W N

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mattie Stokes
(b) Address 535 Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director A. HALSTEAD
(b) Address 918 Druid Hill Avenue

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1948, at M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner. DJM
Date signed 11/29/48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Items must be answered or the word "unknown" or the correct answer. Age is especially important. Physicians: please write the causes of death clearly and legibly.

69444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. 69444

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made on typewriter or with pen and ink. Do not use pencil. Do not abbreviate. Give exact place of death and correct age in all cases. Cause of death must be certified for every death, no matter how long or short the attendance may have been. Even though a coroner may subsequently hold an inquest, the physician in charge of the case must certify the cause of death if he was in attendance during the last illness. Information as to cause of death is required by law and must be given. Personal and statistical particulars must be furnished by the person best qualified to supply the information. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Fullerton
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9012 Ridge Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: SARAH LILLIAN [redacted] WIENERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife: John Wieners (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 17-1889

8. AGE: Years 59 | Months 3 | Days 25 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: at home

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant: Mrs. John Wieners
(b) Address 9012 Ridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Balto
Location

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road.

19 DEC 14 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12 1948, at 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1948 to 12-12 1948, and that I last saw her alive on 12-12 1948.

Immediate cause of death	Duration
(a) Carcinoma of gall bladder & metastasis	
Due to	
Due to	
Other Conditions	

(include pregnancy within 3 months of death)

Date of operation 11-17-48
Major findings of operation: Ca of G.B.
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature WWB internes. Md M. D.
Address WBGH. Date signed 12-12-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69445

69445 Battaglia
5829 Belair

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Occupation is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5101 Arabia Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5101 Arabia Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SALVATORA BONSIERO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Joseph Bonsiero
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, ~~1898~~ 1893

8. AGE: Years	Months	Days	If less than one day
55 ~~(50)~~	6	10/12	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Pasquale Cammaratta
13. Birthplace Italy

MOTHER
14. Maiden Name Rosaria Cimino
15. Birthplace Italy

16 (a) Informant Mr. Joseph Bonsiero
(b) Address 5101 Arabia Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10th 1948, at 6.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6/1948 to 12/10/1948. and that I last saw h~~e~~r alive on 12/10/1948.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertensive Cardio-Vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. T. Battaglia M.D.
Address 5829 Belair Rd Date signed 12/13/48

VS 193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 65246

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 E 41st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 E. 41st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte George.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29, 1862

8. AGE: Years	Months	Days	If less than one day
86	3	14	hr. min.

9. Birthplace England.
(Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business.

FATHER
12. Name Alfred George
13. Birthplace England.

MOTHER
14. Maiden Name Salah ?
15. Birthplace England

16 (a) Informant Clarence E. Frock.
(b) Address 817 E 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave.

18 (a) Funeral director Austin E. Donovan.
(b) Address 3638 Roland Ave.

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Huntington-Williams, M[illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1948, at 1 36 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1948 to Dec 12 1948, and that I last saw h[illegible] alive on Dec 12 1948.

Immediate cause of death	Duration
Hypertension-Cardio-vascular	
Due to Renal Failure	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave. Date signed

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. 66947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be entered. If unknown, write "unknown." Do not use abbreviations. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St.

(c) ~~Hospital or~~ institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1623 Booker St. (If rural give location) ~~BOOKER St.~~

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME James Albert Bowie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3-24-96

8. AGE: Years 52 | Months 8 | Days 18 | If less than one day: hr. 19 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name James A Bowie

13. Birthplace West River, Md.

MOTHER

14. Maiden Name Mary Brown

15. Birthplace St. Mary's Co. Md.

16 (a) Informant James A Bowie

(b) Address (from admission record)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Thos. Francis A. Hemsley

(b) Address 578 W. Biddle St.

19 DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12- 1948, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20- 1948 to 12-12 1948, and that I last saw him alive on 12-12 1948.

Immediate cause of death Uremia

Due to Malignant Hypertension

Due to Chronic glomerulonephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. E. Grady, M.D.

Address Provident Hosp Date signed 12-13-48

VS 182

59148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 66148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Ordinary supposition is not information. Information should be given even though correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3411 LIBERTY HEIGHTS
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 S. Potomac Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE LOUISE HOLLMANN

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Frederick D. Hollmann
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr) April 2, 1856

8. AGE: Years 92 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER
12. Name Frederick Bucksath
13. Birthplace Germany
14. Maiden Name Katherine L. Rattenholz
15. Birthplace Germany

16 (a) Informant Mrs. Marie Weinhardt
(b) Address 512 S. Potomac Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 12/14/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 14 1948 (Date rec'd by registrar) **(b)** Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1948, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1948 to Dec 12 1948; that I last saw h[illegible] alive on [illegible] Dec 12 1948.

Immediate cause of death # Uremia — Duration 3 days
Due to Hypertensive Cardio Vascular Disease — Duration unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Coleman M.D.
Address 639 W Lanvale Date signed 12/13/48 M.D.

VS 150

69149

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 69149

CERTIFICATE OF DEATH 195E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Riviera Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. Dale Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PATRICIA O. WARREN ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1941

8. AGE: Years	Months	Days	If less than one day
7	5	3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas B. Warren
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Erma E. Otwell
15. Birthplace Philadelphia, Pa.

16 (a) Informant Mr. Thomas B. Warren
(b) Address Dale Rd., Riviera Beach

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location Glen Burnie, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Maryland

Thurlington Williams, M.D. Thurlington Williams, M.D. Registrar
DEC 14 1948
DEC 15 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1948, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of right ulna and radius
Extensive infection of right forearm
~~Due to~~ Toxic changes in all organs.

Other Conditions Hospital history of tetanus.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-4-48 at ? M.
(b) Where did injury occur? Dale Rd., Riviera Beach
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Accidently pushed or fell while playing

23. Signature George G. Merrick M.D. Medical Examiner.
Date signed 12/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B ✓

Registered No. 669450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4004 Belle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4004 Belle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS PHILLIP BOLGIANO

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary A. Bolgiano
nee Hoffacker 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1866

8. AGE: Years	Months	Days	If less than one day
82	9	25	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Gilbert Bolgiano
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ella Kirk
15. Birthplace Baltimore

16 (a) Informant Mrs. Mary A. Bolgiano
(b) Address 4004 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1948, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24th 1946 to Dec 11th 1948 and that I last saw him alive on Dec. 10th 48

Immediate cause of death: Myocardial Insufficiency — Duration: 1day
Due to: Prostatic Carcinoma — Duration: 2 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Wilson M. D.
Address 617 W. 40th St Date signed 12/13/48

VS 150

9451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 69451

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4036 Roland Ave.
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4036 Roland Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE W. BORING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Mary Virginia Boring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1867

8. AGE: Years	Months	Days	If less than one day
81	4	3	hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)
10. Usual Occupation Plastering Contractor(Rtd)
11. Industry or business

FATHER
12. Name Mordecai C. Boring
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Eliza Burns
15. Birthplace Carroll Co., Md.

16 (a) Informant Mr. William Boring
(b) Address 4036 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/48 (month) (day) (year)
(c) Cemetery or crematory
Location Hampstead, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (Date rec'd by registrar) [illegible] Registrar

DEC 14 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1948 at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1941 to Dec 12 1948, and that I last saw him alive on Dec 12 1948.

Immediate cause of death Uremia - Sclerosis

Due to age

Due to

Other Conditions Pneumonia (secondary) & terminal bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? none (Specify type of place) While at work?
(e) Means of injury none

23. Signature D. Contee Stuart M.D.
Address 717 Park Ave. Balto. Md. Date signed Dec 14/1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of information under each heading must be complete and correct. Age is especially important. Physicians: please write the causes of death clearly and legibly.

G69452 B.C. 48-16781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104a

Registered No. G69452

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1045 W. Lexington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SANDRA (LONG) HALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1948

8. AGE: Years	Months	Days	If less than one day
~	4	7	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Joseph Hall
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Anna Carter
15. Birthplace Baltimore, Mary1

16 (a) Informant Joseph Hall.
(b) Address 1045 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14, 1948. (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn.

Location

18 (a) Funeral director KATIE R. WILLIAMS

(b) Address 322 N. Schroeder Street

19 (a) DEC 14 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948, at 8:05PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Upper Respiratory Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner

Date signed 12-13-48

G69453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G69453

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 S. Highland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 E. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Myers

3 (b) If veteran, name war: no.
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 11 1861.
8. AGE: Years 67. Months 2 Days 6 If less than one day hr. min.
9. Birthplace Baltimore Md. (town, county, and state)
10. Usual Occupation Store Keeper
11. Industry or business

FATHER
12. Name Ferdinand H. Myers.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Julia A. Rossman
15. Birthplace Baltimore Md.

16 (a) Informant Ella M. Lasey
(b) Address 2403 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/1928 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Sor. Ritchie Highway

18 (a) Funeral director WENDELL J. GIESE
(b) Address 312 S. Highland Ave

19 DEC 14 1928 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10-1928 19 , at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-1926 to 12-10-1928, and that I last saw h alive on 12-7-1928.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 months
Due to: Hypertension — 2 yrs.
Due to
Other Conditions: Obesity

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Costantini, M.D.
M. D.
Address 2300 Conkling St. Date signed 12-13-1928

VS 153

G69454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69454

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Please answer all questions. If any question does not apply, write "None" or "Unknown" so that no space will be left blank. Please correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Loreley (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Josephine A. Schaech (JOSEPHINE A? SCHAECH)

3 (b) If veteran, name war ----

3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph J. Schaech
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Apr. 8, 1875.

8. AGE: Years	Months	Days	If less than one day
73	8	4	hr. min.

9. Birthplace Germany (Town, County, and state)
10. Usual Occupation Retired.
11. Industry or business House Work.

FATHER
12. Name Lawrence Soter
13. Birthplace Germany

MOTHER
14. Maiden Name ? Kihn
15. Birthplace Germany

16 (a) Informant Joseph J. Schaech
(b) Address Loreley, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-48. (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4730 Belair Rd.

18 (a) Funeral director Charles L. Zeller.
(b) Address 901 S. Conkling St.

19 (a) [illegible] (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 · 12 · 1948, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 · 23 1948, to 12 · 12 1948, and that I last saw h[illegible] alive on 12 · 12 1948.

Immediate cause of death Respiratory Failure — Duration

Due to Cerebral Vasc. accident

Due to

Other Conditions Left monoplegia and left facial paralysis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation?

of autopsy?

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. O'Callaghan M. D.
Address Bon Secours Hosp. Date signed 12-12-1948.

069155

BALTIMORE CITY HEALTH DEPARTMENT ✓ D-69455 Registered No. 069155

CERTIFICATE OF DEATH 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 Myrtle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PRISCILLA (SCROGGINS) SCOGGINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 52 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John Johnson
13. Birthplace Maryland

MOTHER 14. Maiden Name Agnes Gray
15. Birthplace Maryland

16 (a) Informant Edward M. Johnson
(b) Address 234 Gilmore Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery or crematory mt Auburn
Location md

18 (a) Funeral director THOMAS E. KELSON
(b) Address 1303 Pressman Street

DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 12-13-48

VS 151

669456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 669456

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grace Wiltins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-21-1894

8. AGE: Years 53 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Gettings

13. Birthplace Cape Charles Va

MOTHER 14. Maiden Name Grace Gettings

15. Birthplace Cape Charles Va

16 (a) Informant Grace Martin

(b) Address 906 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem.

Location Baltimore Md

18 (a) Funeral director Elroy D. Wilson

(b) Address 1005 Brantley Ave

19 (a) DEC 14 1948 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 19 48 at 1:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1948 to Dec 12 1948 and that I last saw her alive on Dec 12 1948.

	Duration
Immediate cause of death: Coronary occlusion	30 min.
Due to: Coronary H.D.	4-5 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Garland Shindell Jr M. D.

Address 902 W. Franklin Date signed 12-13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69457

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G69457

Registered No. 24747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 N. Central Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N. Central Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	W

6 (b) Name of husband or wife Henry Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1886

8. AGE: Years	Months	Days	If less than one day
62	10	18	hr. min.

9. Birthplace Blacksburg Va.
(Town, county, and state)

10. Usual Occupation D
11. Industry or business –

FATHER
12. Name Charles Jones
13. Birthplace Brunswick Co.

MOTHER
14. Maiden Name Elizabeth ?
15 Birthplace Brunswick Va.

16 (a) Informant Helen Chatham
(b) Address 715 N. Central Ave.

17 (a) Burial (b) Date thereof Dec. 14-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brantley ave
Huntington Williams Md

19 (a) DEC 14 1948 (Registrar)
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1948 at 1205 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Dec 10 1948, and that I last saw her alive on Dec. 10 1948.

Immediate cause of death	Duration
Lobar Pneumonia	5 wks
Due to	
Due to	
Other Conditions Cystitis	10 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R Blighton M. D.
Address 501 Cherry Hill Rd. Date signed 12-11-48

VS 190

G69458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69458

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1443 Andre St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1443 Andre St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agie or Aggie Woznalis

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Adam

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not know

8. AGE: Years 83 | Months — | Days — | If less than one day hr. min.

9. Birthplace Lithuanian (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER | FATHER

12. Name ? Woznalis

13. Birthplace Lithuanian Not know

14. Maiden Name Not know

15. Birthplace Lithuania

16 (a) Informant Mr. Geoge Woznalis

(b) Address 1443 Andre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16-48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Brooklyn

18 (a) Funeral director John A Strehlau

(b) Address 623 S. Paca St

19 (a) DEC 14 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1948 at 3P, M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1948, to Dec. 12 1948, and that I last saw h[er] alive on Dec. 12, 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration 4 Days.

Due to Arteriosclerosis — 3 yr. +

Due to

Other Conditions Chronic Myocardial degeneration — 3 yr. +

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. J. Collard M. D.

Address 707 E. Fort Ave Date signed 12-13-48

VS 150

83a

G69459 #96751

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G69159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lundale.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Main St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Tesse

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-27-93

8. AGE: Years	Months	Days	If less than one day
54	11	16	hr. min.

9. Birthplace Indiana -
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name	James Streaty
FATHER — 13. Birthplace	Ohio -
MOTHER — 14. Maiden Name	Florence Larry
MOTHER — 15. Birthplace	Ohio

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12 15 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 DEC 14 1948 (Date rec'd by registrar) (Signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1948 at 9 15 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1948 to Dec 12 1948 and that I last saw her alive on Dec. 12 1948

Immediate cause of death	Duration
Monocytoma involving lung, nodes spleen,	4 mo.
Due to Pleural and abdominal nodes	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Monocytoma as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard S Ross M.D.
Address Johns Hopkins Hosp Date signed 12/12/48

VS 150

G69460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G69460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore General Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3436 ParkHeights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon Zirlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anne Nee Katz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 1, 1913

8. AGE: Years 35 | Months 7 | Days 14½ | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Isaac Zirlin
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta ?
15. Birthplace Russia

16 (a) Informant Anne Zirlin
(b) Address 3436 ParkHeights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Mishkin Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION 12.25

20. DATE OF DEATH December 14 1948, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1948 to Dec 13 1948 and that I last saw him alive on Dec 13 1948.

Immediate cause of death: Pulmonary Edema
Congest. Ht Failure
Due to Rheumatic Heart Disease

Duration: 6 hours, 1 month, 3 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M. D.
Address 8 E W 36th Date signed 12/14/48

VS 150

669161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered correctly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address City Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street and number 1809 Pine Heights Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Welsh Walczak

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26-85

8. AGE: Years	Months	Days	If less than one day
63.	7	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Poland

MOTHER
14. Maiden Name Catherine Stanick
15. Birthplace Poland

16 (a) Informant Mrs. C. Gegorek
(b) Address 1821 Gough St

17 Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17-48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Ozegowski
(b) Address Eastern Ave.

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Dec. 1948 at 11:20 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer, Jr. M.D. Medical Examiner.
Date signed 13 Dec. 48

VS 191

669462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. 669462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1447 Richardson Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 1

(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1447 Richardson Street

(If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Margaretha E. Koehler (Kohler)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	married

6 (b) Name of husband or wife Max Koehler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/6/92

8. AGE: Years	Months	Days	If less than one day
56	11	5	hr. min.

9. Birthplace Russia

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Domestic

FATHER

12. Name John Heinrich

13. Birthplace Russia

MOTHER

14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Max. Koehler, husband

(b) Address 1447 Richardson Street

17 (a) Burial (b) Date thereof 12/ 15/ 48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Ritchie Highway

18 (a) Funeral director Lilly & Zeiler , Inc.

(b) Address 403 S. Wolfe Street

19 (a) DEC 14 1948 (b) Huntington Williams, M.D.

(Local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11/ 1948, at 525A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1947 to 12/11 1948.

and that I last saw h.. alive on 12/10 1948.

Immediate cause of death	Duration
General Carcinomatosis	
Due to Grade 3 Papillary adenocarcinoma (ovary right)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Nov 15, 1948.

Major findings of operation: Metastatic adeno carcinoma of abdominal contents & organs

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature L. Parsano M. D.

Address Date signed

VS 150

X

G69463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G69463

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 Ensor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Ensor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas J. Hogan

3 (b) If veteran, name war no

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine J. Hogan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18 1876

8. AGE: Years 72. Months 0 Days 26 If less than one day 5 hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Retired Foreman

11. Industry or business Balto. City Water Dept.

FATHER
12. Name Peter Hogan
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen McKenna
15. Birthplace Ireland

16 (a) Informant Mrs. Catherine J. Hogan
(b) Address 1104 Ensor St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Dec 16 1948 (month) (day) (year)

(c) Cemetery or crematory Mount Calvary
Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Conklin
(b) Address 924 E. Eager St Baltimore, Md

19 (a) DEC 14 1948 (Date received) **(b)** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13. 1948 at 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Dec 1948 to 13 Dec 1948, and that I last saw h[illegible] alive on 28 Nov 1948

	Duration
Immediate cause of death: Cerebral Coma	Immediate
Gangrene of toes of right foot.	2 mos.
Due to arteriosclerosis	
Due to 0	
Other Conditions Coronary Disease of the Heart - Chr. (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfield M. D.
Address 714 E. Preston St Date signed 14 Dec 48

V S 150

97

669164 B.C. 48-18227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 669164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28 S. Decker Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 S. Decker Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kathleen Rappold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26 1948

8. AGE: Years	Months	Days	If less than one day
	3	18	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Rappold
13. Birthplace Balto Md

MOTHER
14. Maiden Name Elizabeth Paszkiewicz
15. Birthplace Balto Md

16 (a) Informant William Rappold
(b) Address 28 S. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15 1948 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave

18 (a) Funeral director John F Duda
(b) Address 2829 Hudson St.

19 (a) DEC 14 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1948 at 3-40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Dec 14 1948. and that I last saw h alive on Dec 7 1948.

Immediate cause of death	Duration
Malnutrition	
Due to Monocytic Leukemia acute	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward R. Frey Jr. M.D.
Address 2 W. Read St. Date signed 12/14/48

VS 150

669465

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 131a

Registered No. 669465

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 Brunt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Pierce Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-24-6247

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Robert Wilson
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) November 29-1911

8. AGE: Years	Months	Days	If less than one day
37 36	—	14	hr. min.

9. Birthplace Roanoke Va.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Salis Pierce
13. Birthplace Roanoke Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Roanoke Va.

16 (a) Informant Robert Wilson
(b) Address 2027 Brunt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-48 (month) (day) (year)
(c) Cemetery or crematory Roanoke
Location Roanoke Va.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh Street

DEC 14 1948 Washington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 1948, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1948 to Dec 12 1948 and that I last saw her alive on Dec. 13 1948.

Immediate cause of death: Subarachnoid Hemorrhage.
Due to Unknown
Due to
Other Conditions Acute Gastritis

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Of autopsy: Subarachnoid Hemorrhage Hypertension: Benign, Gastritis

Duration: 4 days.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. G. Bigsby Jr.
Address Provident Hosp. Date signed 12-15-48

VS 139

Medical Exams case

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G69466

Released to Hosp. CERTIFICATE OF DEATH 125a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julius Bowles Julius Ellsworth Bowles

3 (b) If veteran, name war None

3 (c) Social Security Account No. 215-187-460

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-9-1879

8. AGE: Years 29 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name William Bowles

13. Birthplace Va.

MOTHER 14. Maiden Name Bessy Johnson

15. Birthplace Va.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)

(c) Cemetery or crematory Carbutus Memorial Park. Location

18 (a) Funeral director Robert L. Conway

(b) Address 1216 N. Caroline St

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1948 at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death Acute Hepatic Insufficiency — Duration

Due to Probable hepatic-toxic type as yet undetermined

Due to

Other Conditions CERTIFICATION APPROVED BY Howard J. Haddaway, M.D. CHIEF OR ASST. MEDICAL EXAMINER

(Include pregnancy within three months of death)

Operation: Dr. Wm. C. Kahmer M. D. PHYSICIAN

Date of operation

Major findings of operation:

Contused wounds of trunk, with fracture of ribs and pneumothorax

Underline the cause to which death should be charged statistically.

of autopsy gastritis, hypostatic pneumonia

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. D. Jackson

Address The Johns Hopkins Hosp Date signed 12/13/48 M. D.

VS 155 To be approved by Med Exam

X

669467. GRAYSON 669467.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1555 Leslie Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1555 Leslie Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Grayson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of wife: Emma
6 (c) If alive, give age: 48 years
7. Birth date of deceased (mo., day, yr.) 8/8/1892
8. AGE: Years 56 Months 4 Days 4 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Samuel Grayson
13. Birthplace Maryland

MOTHER
14. Maiden Name Rose Bowie
15. Birthplace Maryland

16 (a) Informant: Iva Moore
(b) Address 1555 Leslie St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 16 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Robert C. Jennings
(b) Address 2115 Madison Ave

19 (c) DEC 14 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/48 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1948 to 12/13 1948 and that I last saw h[illegible] alive on 12/12 1948

Immediate cause of death — Duration

Coronary Occlusion

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature
Address 2139 Druid Hill Ave Date signed 12/13/48 M. D.

VS 150

MEDICAL EXAMINERS CASE 669168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3417 East Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3417 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME George Blank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Katherine Walz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1858

8. AGE: Years	Months	Days	If less than one day
90	11/10	1	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant John G. Blank
(b) Address 3417 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cemetery
Location German Hill Rd.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto. 31, Md.

19 (a) DEC 14 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 12 1948 at 5:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 DEC. 1948 to 12 DEC. 1948 and that I last saw h[illegible] alive on DEC. 11 1948.

Immediate cause of death	Duration
FRACTURE ILIUM	8 DYS
CONTUSIONS SCALP ART. ARM	8 DYS
Due to FALL DOWN STEPS	DEC. 4, 1948
Due to	
Other Conditions ARTERIOSCLEROSIS, GEN.	20 YRS.

(Include pr[illegible] CERTIFICATION APPROVED BY
Date of operation
Major findings of operation:
Howard D. Kulaus M. D.
of autopsy: CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/8
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence DEC. 4 1948 at 6.30 A. M
(c) Where did injury occur? BALTIMORE (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? NO
(e) Means of injury, FELL DOWN STEPS, Inside

23. Signature Benjamin Hilpert M. D.
Address 124 S. HIGHLAND AVE Date signed 12/12/48

VS 150

G69169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

Registered No. G69169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City ~~or town~~ Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 E. 25th St., Balto. 13, Md.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louise Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	white	married

6 (b) Name of husband ~~or wife~~ John E. Thompson
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/1883

8. AGE: Years	Months	Days	If less than one day
65	9	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

MOTHER / FATHER
12. Name George Koebel
13. Birthplace Germany
14. Maiden Name Louise Hotz
15. Birthplace Richmond, Virginia

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Rd., Balto. 15, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Parkswood Mem
Location Baltimore Md

18 (a) Funeral director Francis Coppersmith
(b) Address 1606 N. North Ave.

19 (a) DEC 14 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13 1948, at 5:32 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1948, to 12/13 1948, and that I last saw h[illegible] alive on 12/13 1948.

Immediate cause of death Confluent lobular pneumonia marked at base — Duration: 4 days

Due to Leukemia — Duration: over

Due to — Duration:

Other Conditions Cerebral oedema & frontal lobe atrophy — Duration: ?
(Include pregnancy within 3 months of death)

Date of operation Autopsy 12/13/48

Major findings of operation: as above & plasma tumor & marked

of autopsy: arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel P. Glazer M. D.
Address 3326 Old Frederick Rd. Date signed 12/13/48

29

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

Registered No. 069470

069470

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 10 1/2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1248 W. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PEARL CARPENTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1923

8. AGE: Years	Months	Days	If less than one day
25	3	25	hr. min.

9. Birthplace Johnson County, N.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Carpenter
13. Birthplace North Carolina

MOTHER
14. Maiden Name Naissie Carpenter
15. Birthplace North Carolina

16 (a) Informant Naissie Carpenter
(b) Address Middlesex Route 1

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Wilson, North Carolina

18 (a) Funeral director MRS. ROBERT A. ELLIOT & DGT.
(b) Address 1129 N. Carolina Street

19 DEC 14 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1948, at 3:10PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Generalized peritonitis, due to
ruptured tuboovarian abscess.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/10/48

VS 151

No pregnancy X

G69171

ES-122336

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G69171

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVENUE 6-3
(c) Hospital or institution: BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 133 N. Bradford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Kopp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Wm. C. Kopp - deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1884

8. AGE: Years	Months	Days	If less than one day
64	-	15	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name George Rumbel
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Wolfe
15. Birthplace Germany

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVENUE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Schwartz Cemetery
Location O'Donnell St., Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison St.,

19 (a) DEC 14 1948 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13 1948, at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23 1948 to 12-13 1948, and that I last saw her alive on 12-13 1948.

Immediate cause of death	Duration
(a) Uremia	1 wk.
Due to (b) Chronic Pneumonia	1 wk.
Due to (c) Cancer: Diab. Mellitus	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. T. Ward M. D.
Address 13 C 6 Date signed 12-13-48

V S 150

X

48

65172 BALTIMORE CITY HEALTH DEPARTMENT 65172

CERTIFICATE OF DEATH 54a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3203 Clarence Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Clarence Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HELEN M. GETZ

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	218-01-1120	Female	White	Married

6 (b) Name of husband or wife Robert W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4, 1917

8. AGE: Years	Months	Days	If less than one day
31	2	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business

FATHER
12. Name Albert C. Jones
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Mamie M. Rose
15. Birthplace Baltimore, Co., Md.

16 (a) Informant Robert Getz
(b) Address 3203 Clarence Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore Co., Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 15 1948 (Date rec'd by registrar) (b) Huntingdon & Williams, M

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 1948 at 3:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1944 to Dec 13 1948 and that I last saw h.. alive on Dec 13 1948

Immediate cause of death Glioma of Left Cerebral Hemisphere — Duration 5 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan 16, 1944

Major findings of operation Glioma of Brain

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Allen Deckert
Address 1114 St Paul St Date signed 12/13/48 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

669173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No. 669173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Genevieve Grantlin.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	White	Married

6 (b) Name of husband or wife Exist

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11th 1892

8. AGE: Years	Months	Days	If less than one day
56	3	1	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Rommel
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Md.

16 (a) Informant Records
(b) Address St. Agnes Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 15 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12th 1948, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1948 to 12/12 1948 and that I last saw h alive on 12/11 1948.

Immediate cause of death	Duration
Acute Respiratory failure	
Due to Tracheo-bronchial obstruction	
Due to Carcinoma of Larynx	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Left ventricular hypertrophy Visceral congestion

PHYSICIAN
Underline the cause to which death should be referred for statistical tabulation.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen K. Padmanis M. D.
Address St. Agnes Hosp. Date signed 12/12/48

665174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 665174

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5605 Lothan Road
(c) Hospital or institution:

27-8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5605 Lothan Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E. MURPHY

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Elizabeth M.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 23, 1880

8. AGE: Years	Months	Days	If less than one day
68	6	21	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: Jeremiah Murphy
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary Murphy
15. Birthplace: Baltimore, Md.

16 (a) Informant: Chester H. Weis
(b) Address: 5605 Lothan Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/48 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1215 St. Paul St.

19 DEC 15 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1948 19 , at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1948, to Dec 14 1948, and that I last saw h IM alive on Dec 13 1948.

Immediate cause of death: Myocardial-Renal Disease. — Duration: 5 YRS
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Thomas F Carozza
Address: 5214 Harford Rd Date signed: 12/14/48

VS 150

663175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

Registered No. 663175

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6577 St. Helena Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: GEORGE M. ROBERTS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alma E. Roberts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1898

8. AGE: Years	Months	Days	If less than one day
50		24	hr. min.

9. Birthplace Windsor, Virginia
(Town, county, and state)

10. Usual Occupation Steel Worker
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant: William J. Price
(b) Address 6577 St. Helena Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15, 48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Frederick Rd., Balto., Md.

18 (a) Funeral director ROLAND L. FISHER
(b) Address 2112 Dundalk Avenue

19 DEC 15 1948 (Date received by registrar) (b) Huntington Williams M.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1948, at 12 Noon

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to carbon monoxide Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-12-48 at ? A. M.
(b) Where did injury occur? 6577 St. Helena Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury: burners on but unlit on stove

23. Signature Earl M. Boyer M.D.
Medical Examiner.
Date signed 12-13-48

VS 191

69176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 69176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-
(c) Hospital or institution West Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3631 Liberty Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Flax

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Dorothy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
48	8		hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Maintainence man

11. Industry or business

FATHER
12. Name Emanuel
13. Birthplace Poland

MOTHER
14. Maiden Name Mary
15. Birthplace Poland

16 (a) Informant Dorothy Flax
(b) Address 3631 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eastern Place

19 (a) DEC 15 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Dec. 1948 at 6:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer D. M.D.
Medical Examiner.
Date signed 14 Dec. 48

VS 191

X

Evidence for corrections of Items 1, 2, 10, 20, 21 & 22 A, B, C, D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G69177

DEC 14 1948

1. PLACE OF DEATH: (a) Baltimore City, Maryland — Found: ~~Chesapeake Bay in the vicinity of Ft Knox~~ Washed ashore at Sparrows Pt.
(b) Street address — Found
(c) Hospital or institution: FOOT OF 2100 BLOCK OF EAST FORT AVE.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Gaithersburg (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME SAMUEL DORSEY OWINGS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1906

8. AGE: Years	Months	Days	If less than one day
42		2	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ~~none~~ FARM LABORER

11. Industry or business

FATHER
12. Name Thomas Owings
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Royer
15. Birthplace Maryland

16 (a) Informant Thomas Owings (father)
(b) Address Gaithersburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 (month) 29 (day) 1948 (year)
(c) Cemetery or crematory Doctor Willis
Location Montgomery Co Md

18 (a) Funeral director Roy W Barber
(b) Address Poolesville Md

19 (a) 11/29/48 (Date rec'd by registrar) (b) Rosser Registrar
DEC 15 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, H 1948, at 9:00 AM

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident PROBABLE, suicide ☐, homicide ☐, and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Undetermined Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found 10-9-48 at approx. 24-1 9:00 A.M.
(b) Where did injury occur? Found Ft. 2100 Blk. of E. Fort Ave. Sparrows Pt. near Tiknol
(c) Did injury occur at home, on farm, industrial place, in public place? PUBLIC PLACE ~~washed ashore~~ While at work? no
(d) Means of injury undetermined FOUND DROWNED

23. Signature George G. Merrill, M.D. M.D.
Medical Examiner.
Date signed October 11, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

LCH- 116382

Registered No. 669178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Buxton Post Office (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB GAMBER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/17/1858

8. AGE: Years	Months	Days	If less than one day
89	11	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired Farmer
11. Industry or business —

FATHER
12. Name William Gamber
13. Birthplace Pa.

MOTHER
14. Maiden Name Maria Haines
15. Birthplace Md.

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Providence Cemetery
Location Bantley, Carroll Co. Md

18 (a) Funeral director Um Bergmann & Sons
(b) Address Reisterstown Md

19 (a) DEC 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/48 19 , at 11:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6/48 19 , to 12/13/48 19 , and that I last saw h im alive on 12/13/48 19 .

	Duration
Immediate cause of death: BRONCHOPNEUMONIA	17 DAYS
Due to: ARTERIOSCLEROTIC HEART DISEASE	10 MOS
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 2-2-48 and 2-8-48

Major findings of operation: INCARCERATED VENTRAL HERNIA; SUPRACONDYLAR AMPUTATION, RT. LOWER EXTREMITY

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Gerrigan M. D.
Address BALTIMORE CITY HOSP. Date signed 12-13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

69179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 69479

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 Marydell Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Euclid Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MABEL H. BILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1876

8. AGE: Years	Months	Days	If less than one day
72	4	12	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew J. Bilson
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Lucy J. Phillips
15. Birthplace Va.

16 (a) Informant Mrs. Wm. K. Gaither, Jr.
(b) Address 329 Marydell Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 15 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 1948, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to Dec 13 1948 and that I last saw h alive on Dec 13 1948.

Immediate cause of death
Cystic adenoma of ovary
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 1-1948

Major findings of operation: Carcinoma involving ovary - mixed - type

of autopsy:

Duration
1 1/2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer L. Todd M.D.
Address 2108 St Paul St Date signed 12/14/48

VS 150

G69480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G69480 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 37 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Dzezinski (DZERZINSKI)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Zofia Dzezinski
6 (c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): March 19 1893
8. AGE: Years: 55 Months: 8 Days: 25 If less than one day: hr. min.
9. Birthplace: Poland (Town, county, and state)
10. Usual Occupation: Labor
11. Industry or business

FATHER
12. Name: Stanley Dzezinski
13. Birthplace: Poland

MOTHER
14. Maiden Name: Zuganna Suchocki
15. Birthplace: Poland

16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17 1948 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary cem
Location: Balto. County
18 (a) Funeral director: John M. Welsh
(b) Address: 401 S. Chester Street
19 (a) DEC 15 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1948, at 10 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1948 to Dec 13 1948, and that I last saw h is alive on Dec 13 1948.

Immediate cause of death: Massive pulmonary hemorrhage — Duration

Due to: Chronic anthracosis, fibrosis, & cavitation,

Due to: ? cystic disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: tuberculous cavitation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: William W. Wintersmith
Address: Johns Hopkins Hospital Date signed: 12-15-48 (M.D.)

CERTIFICATE CORRECTED 9-1-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 918

Registered No. G69181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) about 9½ hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 910 N. Fremont Ave.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME FRANK CARTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW 2	219-03-5961

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	col	Married

6 (b) Name of husband or wife Mildred Williams

6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1921

8. AGE: Years	Months	Days	If less than one day
27	3 4	29	hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation Shipping clerk

11. Industry or business Arcade Cleaners & Dyers

FATHER 12. Name Frank Carter BROWN

13. Birthplace Md.

MOTHER 14. Maiden Name Mary ? CARTER

15. Birthplace Md.

16 (a) Informant Records

(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/48 (month) (day) (year)

(c) Cemetery or crematory Balto. National

Location Baltimore, Md.

18 (a) Funeral director Charles R. Low

(b) Address 802 Madison Ave

19 (a) DEC 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1948, at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1948 to Dec. 13 1948, and that I last saw h im alive on Dec. 13 1948.

Immediate cause of death Acute endocarditis with multiple embolization — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John L. Wilson

John L. Wilson, Sr. Surgeon M.D.

Address Clinical Director Date signed 12/14/48

VS 150

G69182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution:
Provident hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARK RICHARD BOWYER

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-4665

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1875

8. AGE: Years 73 | Months 2 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace: Lexington, Va.
(Town, county, and state)

10. Usual Occupation: Porter

11. Industry or business

FATHER
12. Name: Matilda R. Johnson
13. Birthplace: Lexington, Va.

MOTHER
14. Maiden Name: William Bowyer
15. Birthplace: Lexington, Va.

16 (a) Informant: Mr. Mark W. Bowyer
(b) Address: 819 W. Saratoga Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/1948 (month) (day) (year)

(c) Cemetery or crematory: Arbutus Memorial Pk.
Location: Baltimore Co. Maryland

18 (a) Funeral director: Mrs. George H. Holland
(b) Address: 1631 Druid Hill Ave.

19 DEC 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1948, at 12:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10/1948 to 12/11/1948 and that I last saw h alive on 12/11/1948

	Duration
Immediate cause of death: Lobar Pneumonia	
Due to: Bacterial	
Due to:	
Other Conditions: none	

(Include pregnancy within 3 months of death)

Date of operation: none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Huntington Williams M. D.
Address: 1131 Hollins Date signed 12/14/48

VS 150

G69183

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161B

Registered No. G69183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ~~JOHNS HOPKINS HOSPITAL~~ JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Caroline
(c) City or town Preston
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Fluharty

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-10-48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Robert Lee Fluharty
13. Birthplace Md

MOTHER 14. Maiden Name Mary Ellen Wheckton
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Union Cross Cemetery
Location Near Preston, Maryland

18 (a) Funeral director J. J. Trappe & Son
(b) Address Federalsburg, Maryland

19 (a) DEC 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10-1948 to 12-12-1948 and that I last saw him alive on 12-12-1948.

Immediate cause of death: Septicaemia in newborn — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Young M. D.
Address Johns Hopkins Hosp. Date signed 12-13-48

VS 150

G69184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Light Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Light Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Howser

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna I. Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/2/1879

8. AGE: Years	Months	Days	If less than one day
69	1	11	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Boilermaker
11. Industry or business Beth. Steel Co.

FATHER
12. Name Jacob H. Howser
13. Birthplace Md.

MOTHER
14. Maiden Name Mathilda Baumgartner
15. Birthplace Md.

16 (a) Informant Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 12/15/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn

18 (a) Funeral director James L. McCurdy
(b) Address 130 East Fort Avenue

19 (a) DEC 15 1948 (Month, day, year) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 / 13 / 48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 47 to 19 ,
and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	1 year
Due to Hypertension	2 years
Due to Arteriosclerosis	
Other Conditions Gangrene of foot	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Luttes M. D.
Address 1225 Madison St. Date signed

VS-150

× South 12 [illegible] 15 15

G69485 ✓ G69485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 Cathedral (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Summers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1898

8. AGE: Years	Months	Days	If less than one day
50	1	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Band-Keller
11. Industry or business

FATHER
12. Name Wm. A. Summers
13. Birthplace Maryland

MOTHER
14. Maiden Name Mattie Burch
15. Birthplace Maryland

16 (a) Informant Mrs Edgar Layton
(b) Address 930 Mt. Royal Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Fredrick Rd

18 (a) Funeral director John A. Moran
(b) Address 3010 E. Baltimore St.

(a) DEC 15 1948 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 19 48 at 12:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 19 48 to 12/13 19 48
and that I last saw h er alive on 12/13 19 48

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify public place)
(e) Means of injury

23. Signature Clark Blazek M.D.
Address Maryland General (Date signed)

Contractor Williamsport, Md.

669486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55c

Registered No. 669486

669486

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BON SECOUR
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ABOUT 5 Y/O

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 W. BALTIMORE ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TIMOTHY D. KEATING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of ~~husband or~~ wife Kate MARY ELLEN (ENGLAND)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 24, 1874

8. AGE: Years	Months	Days	If less than one day
74	5	18	hr. min.

9. Birthplace COUNTY CORK IRELAND (Town, county, and state)
10. Usual Occupation CONTRACTOR
11. Industry or business PROPRIETOR

FATHER
12. Name DANIEL KEATING
13. Birthplace IRELAND

MOTHER
14. Maiden Name ELLEN C
15 Birthplace IRELAND

16 (a) Informant MISS ELLEN C KEATING
(b) Address 2121 W. BALTIMORE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 15 '48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry H. White
(b) Address 4131 Edmondson Ave Washington Williams, Mgr

19 (a) DEC 15 1948 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1948, at 9 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947, to Dec 12 1948, and that I last saw him alive on Dec 12 1948.

Immediate cause of death	Duration
Hypertensive Arteriosclerotic Cardiovascular disease	10 yrs
Due to	
Due to	
Other Conditions Carcinoma thyroid Gangrene of foot (Include pregnancy within 3 months of death)	6 mo.?

Date of operation Thyroid — 10-2-48 Amputation Dec 6, 1948
Major findings of operation Diabetes
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. G. Sullivan M. D.
Address 1114 St Paul St Date signed Dec 12 1948

X

G69487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G69487 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 S. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 S. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob L. Hutzler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex 79 M

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Minnie Hutzler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1869

8. AGE: Years 79 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Hutzler
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna -------
15. Birthplace Germany

16 (a) Informant Mrs. Minnie Hutzler
(b) Address 504 S. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15/48. (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) DEC 13 1948 (Date rec'd by registrar) (b) Interior Williams Baltimore

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13/48. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 19 48 to Dec 13 19 48 and that I last saw him alive on Dec 13 19 48

Immediate cause of death: Acute Cardiac Failure — Duration: 5 days
Due to: Hypertensive Arterio-Vascular Disease — Duration: unknown
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Rothman M.D.
Address 1911 W. Mosher Ave. Date signed 12/14/48 M. D.

669188 669188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 S. BRUCE ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 S. PAYSON ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA MAE BENNY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband ~~or wife~~ Peter JOHN W
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 27 1883

8. AGE: Years	Months	Days	If less than one day
64	11	26 17	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name — RINEHART
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant MR. MILTON BENNY (SON)
(b) Address 1123 ELMRIDGE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 16 '48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Henry H Withe
(b) Address 4101 Edmondson Ave

19 (a) DEC 15 1948 (Date rec'd by registrar) (b) Registrar

Mortuary for Milton MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 13 1948, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1932 to Dec 13 1948, and that I last saw her alive on Dec 13 1948.

Immediate cause of death	Duration
Cerebral hemorrhage	3 hrs
Due to Hypertension, Chronic myocarditis	14 yrs
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Rales M. D.
Address 4 N. Fulton Date signed 12/14

2 G69189 G69186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. G69189

AB- 124455

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.

(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Dundalk

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2236 Edgewater Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Bortner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Carrie Bortner nee Gerdeman

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 8-22-1880

8. AGE: Years	Months	Days	If less than one day
68	3	21	....hr. ....min.

9. Birthplace Pa. (Town, county and state)

10. Usual Occupation R.R. Worker (Retired)

11. Industry or business B & O. R.R.

FATHER

12. Name Edward Bortner

13. Birthplace Pa.

MOTHER

14. Maiden Name Julia Amick

15. Birthplace Pa.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Cem. Road.

18 (a) Funeral director John G. Connelly

(b) Address 418 Eastern Ave. Baltimore, Md.

19 (a) DEC 1 1948 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12- 1948, at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10- 1948 to 12-12- 1948, and that I last saw h in alive on 12-12- 1948.

Immediate cause of death Sub-acute myeloid leukemia — Duration 2 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. F. Welch M. D.

Address BCH Date signed 12-12-48

V S 150

669490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669490

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 430 Maryland Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM RICHARD BARBER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1857

8. AGE: Years	Months	Days	If less than one day
91 yrs.	6 mos.	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business Haberdashery

FATHER
12. Name Michael Barber
13. Birthplace Italy

MOTHER
14. Maiden Name Catherine Ann Robson
15. Birthplace Maryland

16 (a) Informant Mrs. Mildred Betz (Daughter)
(b) Address Stewart Avenue, Essex, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor Avenue

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Avenue

(a) DEC 15 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1948, at 9:35 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture Skull
Due to
Shock - Renal
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/12/48 at 11:00 A M. Balto. Co.
(b) Where did injury occur? Eastern Ave. Nr. Back River Bridge
(c) Did injury occur at home, on farm, industrial place, in public place? Public place. While at work?
(d) Means of injury Hit by truck?

23. Signature [signature] M.D.
Medical Examiner
Date signed 12/13/48

VS 151

G69191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G-69491

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 S. Poppleton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. Poppleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM O. BURGESS

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Mary B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14th 1871

8. AGE: Years	Months	Days	If less than one day
77	3	-	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired Machinist
11. Industry or business B & O R.R.

FATHER
12. Name John H. Burgess
13. Birthplace Laurel, Md.

MOTHER
14. Maiden Name Sarah Madison
15. Birthplace Washington D.C.

16 (a) Informant Mrs Mary B. Smith
(b) Address 106 S. Poppleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Ave.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) DEC 16 1948 (Date received by registrar)
(b) Filed by Edmund Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1948 at 9.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1948 to Dec 14, 1948 and that I last saw h~~im~~ alive on Dec 14, 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 wk.
Due to Generalized + Coronary Arteriosclerosis	years
Due to	
Other Conditions Chron. Bronchitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abram Goldman M. D.
Address 206 S. Gilmor St. Date signed 12/14/48

VS 150

X

G69492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69492

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 311 S. Fulton Ave
(c) Hospital or institution: 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 S. Fulton Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophia F. Weinkam

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~xxxxx~~ late William J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8 1868

8. AGE: Years	Months	Days	If less than one day
80	8	5	hr. min.

9. Birthplace Bavaria Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Vincent Hauck
13. Birthplace Bavaria Germany

MOTHER
14. Maiden Name Florentine Hauck
15. Birthplace Bavaria Germany

16 (a) Informant Charles V. Chalmers
(b) Address 5625 Okland Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dece/16/48 (month) (day) (year)
(c) Cemetery ~~xxxxxxxx~~ New Cathedral
Location Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 322 S. High St.

DEC 15 19[illegible] (Date received by registrar) (b) Lexington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1948 at 4 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1948 to Dec 13 1948 and that I last saw her alive on Dec 13 1948

Immediate cause of death	Duration
Acute Cardiac failure	
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions Pulmonary Oedema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Hatch M. D.
Address 215 Wilkens Ave Date signed 12/14/48

G69493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G69493

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Dean St
(c) Hospital or institution: Camden Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 W Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Sparrow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Rachel Sparrow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1886

8. AGE: Years 62 Months 8 Days 3 If less than one day hr. min.

9. Birthplace Anne Arundel Co. Md (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business

FATHER
12. Name John Sparrow
13. Birthplace A.A. Co., Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Rachel D. Sparrow
(b) Address 224 Fulton St. Chester Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 15 1948 (Date rec'd by registrar) (b) Registrar
Remington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1948, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1948 to Dec 10 1948 and that I last saw him alive on Dec 10 1948.

Immediate cause of death Bronchogenic Carcinoma of right lung — Duration

Due to

Due to

Other Conditions Malnutrition & Dehydration (Include pregnancy within 3 months of death)

Date of operation 11/30/48

Major findings of operation: Inoperable Carcinoma of right lung

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliott Walden M.D.
Address Camden Hosp Date signed 12/15/48

X

G69494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G69494 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 432 N. Arlington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Arlington Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Kellam

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife Clarence Kellam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1890

8. AGE: Years	Months	Days	If less than one day
58	9	21	hr. min.

9. Birthplace Accomac Co. Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Wise
13. Birthplace Accomac Co. Va.

MOTHER
14. Maiden Name Agnes Hall
15. Birthplace Accomac Co. Va

16 (a) Informant Clarence Kellam
(b) Address 432 N. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 15 1948 (Date rec'd by registrar) (b) Livingston Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1948, at 1:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1948 to 12-14 1948 and that I last saw her alive on 12-13 1948.

Immediate cause of death Cerebral hemmorhage — Duration 2 Days

Due to Cardio-renal vascular disease — 9 Mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E. J. Campler M. D.
Address 63 W. Mt. Carey Date signed 12-14-48

VS 150

G69495 **BALTIMORE CITY HEALTH DEPARTMENT** G69495

CERTIFICATE OF DEATH

Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 957 N. Schroeder St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 957 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Randolph Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Estella Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1874

8. AGE: Years	Months	Days	If less than one day
74	2	10	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Handleman
11. Industry or business

FATHER
12. Name George Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md.

16 (a) Informant Mal Robinson
(b) Address 1037 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 15 1948 (Date rec'd by registrar) Thurston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/48 19 , at 4 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1948 to 12/13/48, and that I last saw h alive on 12/13/48.

Immediate cause of death	Duration
Endocarditis	4 months
Due to Nephritis	4
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter J. Dorsey
Address 2012 Edmondson Ave Date signed 12/14/48 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G69196 ✓ G69196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 439 N. Patterson Park Ave
(c) Hospital or institution: 6 - 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 439 N. Patterson Pk. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Offayrout — A Offayrout

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John F. Offayrout
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 - 1865

8. AGE: Years	Months	Days	If less than one day
83	6	10	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name John McCarron
13. Birthplace Not Known

MOTHER 14. Maiden Name Rose Logue
15. Birthplace Not Known

16 (a) Informant Irene Wimpfler
(b) Address 620 N. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location Edmondson Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St. (Signature of Registrar) Registrar

DEC 15 1948 (Date filed) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1948, at 6 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1948, to Dec. 13 1948, and that I last saw h ER alive on Dec. 11 1948.

Immediate cause of death: Coronary Thrombosis — Duration 2 days
Due to: Arteriosclerosis — ?
Due to: Chronic Congestive Heart Failure — ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Klumes M. D.
Address 2623 E. Monument Date signed 12/14/48

VS 150

X

G69497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G69497

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2806 E. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY ANN KAVANAUGH

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Eugene P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1874

8. AGE: Years	Months	Days	If less than one day
74	4	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Patrick Gribbin
13. Birthplace Ireland

MOTHER
14. Maiden Name Bidget McSherry
15. Birthplace Ireland

16 (a) Informant Mrs Owen McGeeney
(b) Address 4601 Northwood Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by Registrar) (b) for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1948 19 , at 2:15 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 1946, to DEC 14 1948, and that I last saw HER alive on DEC 14 1948.

Immediate cause of death	Duration
CARCINOMA OF LIVER	5 MOs.
Due to CA OF SIGMOID -	1 YR
Due to	
Other Conditions ARTERIOSCLEROSIS.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J Kavanagh M.D.
Address 3614 McElderry St Date signed 12-15-48

VS 150

X

G69198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G69198

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 N. Calvert St.
(c) Hospital or institution: 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES M. BOND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.19,1866

8. AGE: Years	Months	Days	If less than one day
82	9	25	hr. min.

9. Birthplace York, Pa (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

MOTHER / FATHER
12. Name Edward R. Bond
13. Birthplace York, Pa
14. Maiden Name Elizabeth Griffith
15. Birthplace York, Pa.

16 (a) Informant Harvey L. Bond
(b) Address 125 E.Turnbull Ave.Phila,Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore,Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St.Paul St.

19 (a) DEC 15 1948 (Date rec'd by Local Registrar) (b) Towson, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec.14,1948 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1948 to Dec 14 1948 and that I last saw h alive on Dec 12 1948.

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions Acute Cerebrovascular (Include pregnancy within 3 months of death)

Duration: 2 days

Date of operation

Major findings of operation

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Hearn M. D.
Address 3101 Greenmount Ave Date signed Dec 15 1948

VS 150

G69499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G69499 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 25yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 E. North Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Cockrill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe.	White	Married

6 (b) Name of husband or wife Joseph William Cockrill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1879

8. AGE: Years	Months	Days	If less than one day
69	2	22	hr. min.

9. Birthplace Chicago (Town, county, and state)
10. Usual Occupation Hwfe.
11. Industry or business

FATHER
12. Name John E. Quick
13. Birthplace Va.

MOTHER
14. Maiden Name Katherine Hack
15. Birthplace Boonsboro Md.

16 (a) Informant Joseph W. Cockrill
(b) Address 502 E. North Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Charles Town W. Va.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) Date received by Registrar DEC 15 1948 (b) Registrar Cuthbert Williams

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1948 19 at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/ 1948 to 12/14/ 1948.
and that I last saw her alive on 12/14/ 1948.

Immediate cause of death Carcinoma of Rectum and Sigmoid
Due to Colon
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Carcinoma of Rectum

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Roy E. Parsons Jr. M. D.
Address 1211 Eutaw Place Date signed 12/15/48

G69500 LCH-97714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G69500

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB NORRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Florence Norris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/11/1878

8. AGE: Years	Months	Days	If less than one day
70	9	3	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Norris
13. Birthplace Maryland

MOTHER
14. Maiden Name Florence Shock
15. Birthplace Maryland

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery or crematory St Mary's Hampden
Location Baltimore

18 (a) Funeral director Wm Cook Inc.
(b) Address 2217 St Paul St.

19 (a) (b)
(Date rec'd by registrar) Eva Williams Registrar

DEC 15 1948

DEC 16 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14/48 19 , at 1100 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6/45 19 , to 12/14/48 19 , and that I last saw him alive on 12/14/48 19 .

Immediate cause of death BRONCHOPNEUMONIA — Duration 10 DAYS

Due to CEREBRAL THROMBOSIS — 1 MONTH ?

Due to

Other Conditions MYOCARDIAL INFARCTION, OLD
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: NONE

of autopsy: SAME AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jernigan M. D.
Address BALTIMORE CITY HOSP. Date signed 12-15-48

Jernigan 83R

G69501

MEDICAL EXAMINER'S CASE
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G69501 Registered No.

LCH-124047

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 W. Fayette Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH SAUM

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/23/67

8. AGE: Years	Months	Days	If less than one day
81 yrs.	4	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Maryland

16 (a) Informant 4940 Eastern Avenue
(b) Address B.C.H. records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/48 (month) (day) (year)
(c) Cemetery or crematory Chapters
Location Chapters md.

18 (a) Funeral director V. L. Speare Inc
(b) Address 1009 H St N.W. Wash D.C.

19 (a) Dec 15 1948 (Date received by registrar) (b) Filed by Registrar Wilkinson

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14/48 19 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25/48 19 to 12/14/48 19, and that I last saw her alive on 12/14/48 19.

Immediate cause of death Bronchopneumonia — Duration 2 days

CERTIFICATION APPROVED BY
Due to
Due to Howard J. Malchow M.D. pro S.M.T. CHIEF OR ASST. MEDICAL EXAMINER.

Other Conditions Intercostal tenderness fracture left femur — 2 wks
(Include pregnancy within 3 months of death)
Date of operation 11/26/48
Major findings of operation: fractured femur
of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide~~
(b) Date of occurrence 11/23/48 at ? M
(c) Where did injury occur? Balto (City or town) Balto (County) Md (State)
(d) Did injury occur about home, on ~~farm, industrial place~~, in public place? Balto City Hospitals (Specify type of place) While at work?
(e) Means of injury ~~Burn~~ fall to floor

23. Signature [signature] M. D.
Address Balto City Hosp Date signed 12/15/48

V S 150 TO BE APPROVED BY THE MEDICAL EXAMINER

G69502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G69502 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 7.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
5 (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 McElderry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CHARLES WILSON

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-09-5400

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma L. Wilson

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) June 25, 1892

8. AGE: Years 56 | Months 5 | Days 16 | If less than one day: hr. min.

9. Birthplace: South River, Maryland
(Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business

FATHER
12. Name: Charles Wilson
13. Birthplace: South River, Maryland

MOTHER
14. Maiden Name: Louise Brown
15. Birthplace: South River, Maryland

16 (a) Informant: Emma L. Wilson
(b) Address: 1616 McElderry Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Baltimore, Maryland

18 (a) Funeral director: ELROY O. WILSON
(b) Address: 1000 Brantly Avenue

19 (a) DEC 15 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11 1948, at 12 Noon

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Spontaneous cerebral hemorrhage

Due to: Hypertensive cardiovascular disease

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner. M.D.
Date signed 12-14-48

VS 151

G69503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G69503

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1119 St. Paul Street

(c) Hospital or institution: Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 4

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) ~~County~~ Baltimore City

(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)

(d) Street No. 1119 St. Paul Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ANNA SCHLEY ABELL

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Arunah S. Abell

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan-8-1870

8. AGE: Years 78 | Months 11 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER

12. Name William C. Schley

13. Birthplace Baltimore, Maryland

MOTHER

14. Maiden Name Ellen Teackle

15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Anna S. Abell (self)

(b) Address 1119 St. Paul Street, City.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Dec. 16-1948 (month) (day) (year)

(c) ~~Cemetery~~ crematory Loudon Park then

Location entombment Greenmount Cemetery

18 (a) Funeral director Stewart & Mowen Company.

(b) Address 108 W. North Avenue, City #1.

19a) 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1948. at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948. to Dec 13 1948.

and that I last saw h[illegible] alive on Dec 13 1948.

Immediate cause of death: Cerebral Haemorrhage — Duration

Due to Arterio Sclerosis Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wallace A Brazier M. D.

Address 1101 St Paul St Date signed 12/14/48

VS 150

G69504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G69504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ABOVE SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. Md. (b) County Bradbury Hts.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5113 T. Street, S. E.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MANLEY, GEORGE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 11, 1884

8. AGE: Years	Months	Days	If less than one day
64	7	4	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Unemployed

FATHER
12. Name Charles Manley
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Weeks
15. Birthplace Va.

16 (a) Informant W W Chambers
(b) Address Washington, D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Suitland Md.

18 (a) Funeral director W W Chambers
(b) Address Washington D.C.

DEC 15 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 19 48, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1948, to 12/15 1948, and that I last saw him alive on 12/15/48 19 .

Immediate cause of death	Duration
Carcinoma of Stomach & Generalized Metastasis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12/10/48

Major findings of operation: Same as above

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald M. D.
Address 1213 Light St Date signed 12-15-48

VS 150

48

G69505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G69505 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Fontaine Convalescent Home 25
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Cambria Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas H. Brophy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife Margaret McCanna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/15/1862

8. AGE: Years	Months	Days	If less than one day
86	3	28	hr. min.

9. Birthplace Indiana
(Town, county, and state)
10. Usual Occupation Ret. Employee Of The
11. Industry or business New York Central R.R.

FATHER
12. Name Dennis Brophy
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna ?
15. Birthplace Ireland

16 (a) Informant Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn, Md.

18 (a) Funeral director James L. McCleary
(b) Address 130 East Fort Avenue

19 (a) 5 1948 (b) Christopher Williams Registrar
(Date filed by registrar)

DEC

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1948, at 59. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 1946 to 12/13 1948, and that I last saw him alive on 12/11 1948.

Immediate cause of death Senility with senile demented — Duration 2 yrs 6 mos 11 days

Due to

Due to

Other Conditions General and cerebral arteris sclerosis — Duration 2
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Deiece
Address 1226 Hutton St. Date signed 12/14/48

162 B

G69506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G69506 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Polaski & Fayette Sts
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~ or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 29 S. Polaski ST. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William J. Law Sr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	W	

6 (b) Name of husband or wife Mary A.
6 (c) If ~~alive~~, give age years

7. Birth date of deceased (mo., day, yr.) 3-27-1869

8. AGE: Years	Months	Days	If less than one day
79	8	18	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Richard C. Law
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Daly
15 Birthplace Ireland

16 (a) Informant Wm. J. Law, Jr.
(b) Address 29 S. Polaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farby
(b) Address Fulton Ave & Fayette St.

19 (a) DEC 15 1948 (b) (Date rec'd by Reg.) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14/1948, at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1948, to 12/14 1948, and that I last saw h~~im~~ alive on 12/14 1948.

Immediate cause of death Cardiac Failure — Duration
Coronary Occlusion
Due to arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William S. Womack
Address Bon Secours Hosp. Date signed 12/14/48 M. D.

X

G69507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G69507 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Dukeland St
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Dukeland St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME Stephen Vincent Bovenza

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maria Budnick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1909

8. AGE: Years	Months	Days	If less than one day
39	6	3	hr. min.

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation Unemployed Barber
11. Industry or business

FATHER
12. Name Vincent Bovenza
13. Birthplace Italy

MOTHER
14. Maiden Name Rose Lanning
15. Birthplace Italy

16 (a) Informant Mrs. Maria Bovenza
(b) Address 1211 Dukeland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-48 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave. & Saratoga St.

19 (a) DEC 15 1948 (Date rec'd by registrar) Chamberlain Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1948, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1948, to Dec. 15 1948, and that I last saw h[illegible] alive on Dec 9 1948.

Immediate cause of death Cardiac Failure — Duration
Due to Rheum. Heart Disease — Duration
Cardiac Enlargement — Duration
Due to Mitral Stenosis & Insuff. — Duration
Tricuspid Insuff. — Duration
Other Conditions Congestive Failure — Duration
Arteriosclerosis — Duration
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester A. Farley Jr. M. D.
Address 2950 Edmondson Date signed Dec 15 '48

VS 150

G69508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. G69508

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairmount & Broadway
(c) Hospital or institution: Church Home & Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Broadway & Fairmount
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Ware

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7 1868

8. AGE: Years	Months	Days	If less than one day
80	2	7	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Mr. George B. Jean
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Emily Watkins Selby
15. Birthplace Baltimore Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16/48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Balto Md

18 (a) Funeral director Ullman Funeral Home
(b) Address 2008 Pulaski Hwy Huntingtown Williams, Md

19 DEC 16 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14/1948, at 7.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/1948 to 12/14/1948 and that I last saw h[illegible] alive on 12/14/1948

Immediate cause of death Cardiac failure

Due to Uremia - bilateral hydronephrosis - Carcinoma

Due to Bladder & metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D W Hunter M. D.
Address Church Home & Hosp. Date signed 12/15/48

VS 150

G69509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69509

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.,
(c) Hospital or institution:
Snyder Nursing Home 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Alvarado Square
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise B. Carson.

3 (b) If veteran, name war: --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George T. Carson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 20, 1868

8. AGE: Years	Months	Days	If less than one day
80	4	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Adam Bitzel
13. Birthplace Germany

MOTHER
14. Maiden Name Anna B. Stein
15. Birthplace Germany

16 (a) Informant Miss Lydia B. Moore
(b) Address 2914 Alvarado Square

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto.

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St.

19 (a) DEC 16 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1948, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 21-May 1948 to 14-Dec 1948.
and that I last saw he alive on 13-Dec 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 day.
Due to Arteriosclerotic Cardio Vascular Disease	May-48
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas W. Edwards M. D.
Address 2746 The Alameda Date signed 14-Dec-48

VS 150

X

Hospital Disposal. BALTIMORE CITY HEALTH DEPARTMENT X ✓ 069510

CERTIFICATE OF DEATH

160a

069510 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County a. a.
(c) City or town Laurel (If outside city or town limits, write RURAL and give town)
(d) Street No. Ft. Meade (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Direy (Girl) Jacqueline Dale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-8-48.

8. AGE: Years | Months | Days: 2 | If less than one day ... hr. ... min.

9. Birthplace: Md. (Town, county and state)

10. Usual Occupation: Child

11. Industry or business

FATHER
12. Name: Lt. Col. Jr. H. Direy
13. Birthplace: Ind.

MOTHER
14. Maiden Name: Helen Boyett
15. Birthplace: Ga

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director: Joy Gerhart
(b) Address

19 (a) DEC 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1948 at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9-1948 to 12-10-1948 and that I last saw her alive on 12-10-1948.

Immediate cause of death: Subarachnoid Hemorrhage — Duration:
Due to: Prematurity
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Subarachnoid Hemorrhage Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Eugene F. Goldstein M. D.
Address: J. Hopkins Hospital Date signed 12-13-48

VS 150

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G69511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. G69511

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaiah Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 226-03-8760

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lucille Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1900

8. AGE: Years	Months	Days	If less than one day
48 yrs,	5	6	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Flanagan Construction Co.

FATHER
12. Name Samuel Jackson
13. Birthplace Virginia

MOTHER
14. Maiden Name Mildred Mormon
15. Birthplace Virginia

16 (a) Informant Lucille Jackson
(b) Address 1613 Madison Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Arbutus, Md.

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman St.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

DEC 16 1948

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1948, at 8:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 3rd degree burns

Due to Body Surface

Other Conditions 3rd degree burns of neck, thorax upper and lower extremities and 80% of body.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/12/48 at 8:00 A.M.
(b) Where did injury occur? Cherry Hill & Terra Firma Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? Yes
(d) Means of injury Explosion of gasoline vapor (during compound)

23. Signature [signature] M.D.
Medical Examiner
Date signed 12/13/48

G69512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G69512

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3720 Woodhaven Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3720 Woodhaven Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 75 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Harry
13. Birthplace Russia

MOTHER
14. Maiden Name Chesna
15. Birthplace Russia

16 (a) Informant Max Miller
(b) Address 3720 Woodhaven Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-48 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Northern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) DEC 16 1948 Huntington Williams Inc Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16-1948, at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 ... to 12/15 1948, and that I last saw h alive on 12/15 1948.

Immediate cause of death	Duration
Terminal Cerebral Arteriosclerosis	3 yrs
Due to	
Due to	
Other Conditions Senile Infection	3 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irma B King
Address 3720 Eutaw Pl Date signed 12/16/48

VS 150

97

G69513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69513

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 E. 28th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Evans

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 3-21-89

8. AGE: Years 59 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace NC (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business

FATHER
12. Name Alex Evans
13. Birthplace NC

MOTHER
14. Maiden Name Marie
15. Birthplace NC

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn, Md

18 (a) Funeral director Leroy S. Wilson
(b) Address 1000 Brantly ave (Huntington Williams, Md)

19 (a) DEC 16 1948 (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-14 1948, at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10-1948 to 12-14-1948, and that I last saw he alive on 19

Immediate cause of death Mesenteric Thrombosis — Duration

Due to Generalized Arteriosclerosis

Due to

Other Conditions Hypertensive Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. M. Millikan
Address Johns Hopkins Hosp. Date signed 12/16/48

VS 159

99

669514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

LCH-125252 124B

Registered No. 669514

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AN ASSURED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals 5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 917 Hillen Street 1 (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME EMMA STEWART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/29/1905

8. AGE: Years	Months	Days	If less than one day
43	10	14	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name ?

13. Birthplace ?

MOTHER

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant B.C.H. records

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 18[illegible] Bluntley ave

19 (a) DEC 16 1948 (Date rec'd by registrar) (b) Huntington-Nottingham Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/48 19..., at 8:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10/48 19..., to 12/13/48 19..., and that I last saw her alive on 12/13/48 19...

	Duration
Immediate cause of death Bronchopneumonia	4 days
Due to Bronchiectasis CLL	?
Due to Infections	
Other Conditions Cirrhosis of liver	one year

(Include pregnancy within 3 months of death)

Date of operation panacentesis

Major findings of operation: 12-8-48

of autopsy: same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature David L. Marine

Address Balto City Hosp. Date signed 12-14 (M. D.) 48

V S 150

669515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 669515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1146 Argyle Ave.

(c) Hospital or institution:

17-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1146 Argyle Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZA YOUNG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife William Young

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 7, 1874

8. AGE: Years	Months	Days	If less than one day
74	7	7	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Smith

13. Birthplace Va.

MOTHER

14. Maiden Name Unknown

15. Birthplace Va.

16 (a) Informant Mr. William S. Young

(b) Address 1146 Arkyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-48 (month) (day) (year)

(c) Cemetery or crematory Old National Cem.

Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle St.

DEC 16 1948 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1948, at 7P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1948 to 12/14 1948 and that I last saw her alive on 12/14 1948.

Immediate cause of death	Duration
Intestinal obstruction (ileus paralyticus)	10 days
Due to	
Due to	
Other Conditions hypertensive cardio-renal disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature RAYNER BROWNE, M. D.

Address 1500 EAST MADISON ST. BALTIMORE 5, MD.

Date signed 12/15/48 M.D.

VS 150

1228

669516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

669516 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 452 Hoberta Ave. 12
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) Mercy
(e) Length of stay in Baltimore (yrs., mos., or days) 22 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 452 Hoberta Ave. or 425 Hoberta
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie May Hall

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Edward Hall
6 (c) If alive, give age: deceased years
7. Birth date of deceased (mo., day, yr.) Dec. 15 1870
8. AGE: Years 78 | Months 0 | Days 0 | If less than one day ..... hr. ..... min.
9. Birthplace Fairfield, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Warren
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Laura Shock
(b) Address 452 Hoberta Ave. Balto. 16, Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Bethel Cem.
Location Highfield Md.
18 (a) Funeral director Paul C. Schenocketh Jr.
(b) Address 3615 Labeaume Ave.
19 (a) DEC 16 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1948, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1948 to Dec. 15 1948 and that I last saw h alive on Dec. 15 1948.

Immediate cause of death Gastro-intestinal bleeding of undetermined origin.
Due to Probable carcinoma Stomach.
Due to
Other Conditions Arteriosclerotic heart disease.
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Carl Myers, M. D.
Address 1536 E. Cold Spring Lane Baltimore 18, Md. Date signed Dec. 15, 48

VS 150

G69517 LCH-125310

BALTIMORE CITY HEALTH DEPARTMENT ✓ 61

CERTIFICATE OF DEATH

Registered No. G69517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BINDING MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Boone Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BLANCHE SILVA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Paulino
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/28/1895

8. AGE: Years	Months	Days	If less than one day
53	8	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Tunstall (d)
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Jackson
15. Birthplace Md.

16 (a) Informant B.C.H records
(b) Address 4940 Eatern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-48 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Park
Location Arlington

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (a) DEC 16 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14/48 19 , at 8:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13/48 19 to 12/14/48 19 , and that I last saw h er alive on 12/14/48 19 .

Immediate cause of death Cardiac failure — Pulmonary edema — Duration one year

Due to Hypertensive cardiovascular renal disease — 4 years

Due to

Other Conditions Diabetes, History of Bronchopneumonia, Terminal — Duration 1 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David H. Marcus M.D.
Address Balto City Hospo Date signed 12-19-48

V S 150

131a

G69518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G69518

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 24½ hrs. 12-5
(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: 312 E. Lanvale St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: (Patient also known as Minnie Quickley) MINNIE BELLE COIE

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: F
5. Color or race: col
6 (a) Single, married, widowed, or divorced: Sep.
6 (b) Name of husband or wife: Harrison Cole
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 6 (?) '98
8. AGE: Years: ? 50 Months: 5 Days: 8 If less than one day: hr. min.
9. Birthplace: Va. (Town, county, and state)
10. Usual Occupation: Hwf
11. Industry or business:

FATHER
12. Name: Wm. H. Scott
13. Birthplace: Va.

MOTHER
14. Maiden Name: Elizabeth Graham
15. Birthplace: Va.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 18-48 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary Cem.
Location: C. P. Co

18 (a) Funeral director: Rayner & Sanders
(b) Address: 1412 E. Preston ave

19 (a) DEC 16 1948 (Date rec'd by registrar) Huntington Maryland Registrar

MEDICAL CERTIFICATION 48

20. DATE OF DEATH: Dec. 14 19..., at 4:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1948 to Dec. 14 1948, and that I last saw him alive on Dec. 14 1948.

Immediate cause of death: Carcinoma left breast with generalised metastasis — Duration: approx. 2 yrs
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

Signature: John L. Wilson
John L. Wilson, Sr. Surgeon 12/26/48
Address: Clinical Director Date signed

VS 180

G69519

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G69519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4107 Massachusetts Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4107 Massachusetts Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Corson R. Hamlet, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	married

6 (b) Name of husband or wife Stella M. Hamlet
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1883

8. AGE: Years	Months	Days	If less than one day
65	0	13	hr. min.

9. Birthplace Savannah, Ga. (Town, county, and state)
10. Usual Occupation Gas Fitter
11. Industry or business Gas & Electric Co.

FATHER
12. Name Edward Hamlet
13. Birthplace Ga.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Walter E. Preisz
(b) Address 204 S. Collins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 16 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/48 19 at 1130 A.M.

21. I certify that I took charge of the remains described above, held an Inspection of Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Sours M.D. Medical Examiner.
Date signed 12/15/48

VS 151

X

669520

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 669520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbot Co.
(c) City or town Oxford
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Alford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary V. Alford
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1863

8. AGE: Years	Months	Days	If less than one day
85	9	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation retired salesman
11. Industry or business

FATHER
12. Name James E. Alford
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Jane Edmondson
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Eliz. Rawlings
(b) Address 1316 Blackburn Court, Balto

17 (a) Burial (b) Date thereof 12/18/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenfield
Location Easton, Md.

18 (a) Funeral director H. E. Newnam & Son
(b) Address Easton Md.

19 DEC 16 1948 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1948 at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1948 to 12/14 1948.
and that I last saw him alive on 12/14 1948.

Immediate cause of death	Duration
Intestinal obstruction due to fecal impaction	
Due to Generalized arteriosclerosis	
Due to Thrombosis Ant. Common Iliac artery, Gangrene of toes & feet	
Other Conditions Coronary sclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Intestinal obstruction, gen. arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Fred Hawkins Jr. M.D.
Address Franklin Square Hosp. Date signed 12/14/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669521

669521 BC-48-06813 106a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 W. West Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER THOMAS TUCK

3 (b) If veteran, name war ———
3 (c) Social Security Account No. ———

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S

6 (b) Name of husband or wife ———
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1948

8. AGE: Years	Months	Days	If less than one day
	9	22	hr. min.

9. Birthplace Baltimore City, Maryland
(Town, county, and state)

10. Usual Occupation ———
11. Industry or business ———

FATHER
12. Name Burkley Tuck
13. Birthplace Virginia

MOTHER
14. Maiden Name Odessa Carrence
15. Birthplace South Carolina

16 (a) Informant Mrs. Odessa Tuck
(b) Address 519 W. West Street

17 (a) Burial (b) Date thereof Dec. 18, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co. Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) DEC 16 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1948 at 10p.05 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute tracheobronchitis.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/15/48

VS 151

G95622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G95622

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Edgevale Rd.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (13)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Edgevale Rd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Walter David Bahn

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
none	217-14-7695	Male	White	Married

6 (b) Name of husband or wife Helen W. Bahn
6 (c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) Jan 20 1877

8. AGE: Years	Months	Days	If less than one day
71	10	25	hr. min.

9. Birthplace York Co - Pa.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business Union Trust Co.

FATHER
12. Name Milton W. Bahn
13. Birthplace New Freedom Pa

MOTHER
14. Maiden Name Ellen S. Emig
15. Birthplace York Co - Pa

16 (a) Informant Mrs. Helen W. Bahn (wife)
(b) Address 611 Edgevale Rd
17 (a) burial (Burial, cremation, or removal) (b) Date thereof Dec 17 48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville
18 (a) Funeral director Stewart & Morris Co.
(b) Address 108 W Mount Ave.
19 DEC 16 1948 (Date rec'd by Registrar) (b) Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1948, at 7 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to Dec 15 1948 and that I last saw h[illegible] alive on Dec 14 1948.

Immediate cause of death	Duration
Myocardial Arterio sclerosis	Gradual
Due to Hypertension.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Moody M. D.
Address 1403 Park ave Date signed 12-16-48

VS 150

B.C.#27025

G69523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G69523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or corporate limits, write RURAL and give town)
(d) Street No. 1115 Rayleigh Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bollack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/6/48

8. AGE: Years	Months	Days	If less than one day
			hr. 15 min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Henry Bollack

13. Birthplace Baltimore Md.

14. Maiden Name Eunice Ethelene Funaris

15. Birthplace Baltimore Md.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 DEC 16 1948 Huntington Williams M.D. (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1948, at 9 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1948 to 12-6 1948 and that I last saw him alive on 19

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Goldstein

Address Hopkins Hospital Date signed 12/7/48 M D

VS 150

69524 X 4 69524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133a

Registered No. 69524

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Kyrian Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 80 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Va Md. (b) County —
(c) City or town Baltimore Newpoint
(If outside city or town limits, write RURAL and give town)
(d) Street No. Newpoint, Va.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Burroughs

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
- - - -	- - - -	m	w	single

6 (b) Name of husband or wife - - - -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep. 12, 1889

8. AGE: Years	Months	Days	If less than one day
59	3	4	hr. min.

9. Birthplace Newpoint, Va. (Town, county, and state)
10. Usual Occupation O.S.
11. Industry or business Seafarer

FATHER
12. Name Wm. S. Burroughs - Va.
13. Birthplace

MOTHER
14. Maiden Name Sarah Harris
15. Birthplace Va.

16 (a) Informant Records
(b) Address U.S. Marine Hospital

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 16 1948 (month) (day) (year)
(c) Cemetery or crematory Location Petersburg Virginia

18 (a) Funeral director Pratt & Steele Co. Balt. B. Mr. Wallace
(b) Address

19 (a) DEC 16 1948 (Date received by registrar) (b) DECEASED

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1948 at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 27 1948 to Dec. 16 1948 and that I last saw h im alive on Dec. 16 1948

Immediate cause of death: Gastric hemorrhage — Duration: 2 days
Due to: Unknown cause
Due to:
Other Conditions: Guillain-Barre syndrome 80 days
Pylonephritis -60 days
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. C. G. Spickmall M. D.
Address U.S. Marine Hospital Date signed 12/16/48
Balto., Md.

VS 190

118

669525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a ✓

Registered No. 669525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 Cliftwood Ave.
(c) Hospital or institution: &

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Cliftwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Freter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Conrad Freter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21st 1859

8. AGE: Years	Months	Days	If less than one day
89	4	22	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Wm. Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Wm. Freter
(b) Address 2011 Cliftwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/48 (month) (day) (year)
(c) Cemetery or crematory Greenly
Location Balto Md.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 DEC 16 1948 Wm. H. Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13th 1948, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Dec 13 1948 and that I last saw her alive on Dec 12 1948

Immediate cause of death Cerebral accident *

Due to Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Conrad L. Richter M. D.
Address 1206 N. Wash. St Date signed 12/19/48

VS 150

Conrad L. Richter

G69526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

184

Registered No. G69526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town New Windsor
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN ALBERT KEENEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16- 1934

8. AGE: Years	Months	Days	If less than one day
14	8	0	hr. min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER
12. Name Norman D. Keeney
13. Birthplace Md.

MOTHER
14. Maiden Name Virgie D. Baugher
15. Birthplace Md.

16 (a) Informant N. D. Keeney
(b) Address New Windsor, Md. R. D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/48 (month) (day) (year)
(c) Cemetery or crematory Rocky Hill Cem.
Location Woodsboro RD. Md.

18 (a) Funeral director D. D. HARTZLER & SONS
(b) Address Union Bridge New Windsor, Md.

19 DEC 16 1948 (Date rec'd by registrar) Huntington for Williams, MD Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1948, at 4.00a M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH malnutrition

Due to Bullet wound of abdomen.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-25-48 at ? M.
(b) Where did injury occur? New Windsor, Carroll Co. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? farm While at work? no
(d) Means of injury Firearms

23. Signature [signature] M.D.
Medical Examiner
Date signed December 16, 1948

140

669527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 669527

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore City Hospital
(c) Hospital or institution: 4940 Eastern Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) D.O.A.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Joseph Moskal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	widowed

6 (b) Name of husband or wife Anna Moskal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Edward Moskal
(b) Address 1015 S. Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17/48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

DEC 16 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1948, at 7 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Dec death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 16 Dec. 48

X

G69528

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93

Registered No. G69528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 East Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY ANNA C. UEHR

3 (b) If veteran, name war No.

3 (c) Social Security Account No. None

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Fred William Uehr

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1877

8. AGE: Years 71 | Months 4 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frederick Landgraf
13. Birthplace Germany

MOTHER
14. Maiden Name Anna E. Yeager
15. Birthplace Germany

16 (a) Informant Mr. Fred W. Uehr
(b) Address 1424 E. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 12/18/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 16 1948 (Date received by Registrar) **(b)** Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1948, at 5.00 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A.S.C.V.D.

Due to

Other Conditions.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royston M.D. (Medical Examiner)

Date signed 12/16/48

669529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

669529 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Bronx Newyork (If outside city or town limits, write RURAL and give town)
(d) Street No. 749 Trinity Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FANNIE Shuster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1866

8. AGE: Years: 82 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Morton
13. Birthplace: Russia

MOTHER
14. Maiden Name: Esther
15. Birthplace: Russia

16 (a) Informant: Harry Janowitz
(b) Address: 4019 Fairview Ave

17 (a) Burial: (Burial, cremation, or removal) (b) Date thereof: 12-17-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Lebanon
Location: Newyork City

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2100 Eutaw Place

19 DEC 16 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1948, at 8 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1948, to 12/16 1948, and that I last saw h[illegible] alive on 12/16 1948.

Immediate cause of death: Cerebrovascular Accident — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Bernard Lasker M.D.
Address: Sinai Hospital Date signed: 12/16/48

65530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2727 Pelham Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 Pelham Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Wilkinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Geo. W. Wilkinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10 1873

8. AGE: Years 75 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Jacob Schwartz

FATHER 13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Catherine Smith

MOTHER 15. Birthplace Balto. Md.

16 (a) Informant Mrs. Helen Schroeder

(b) Address 2727 Pelham Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/44 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto.

18 (a) Funeral director C. D. Fanning & Son

(b) Address 1918 E. Lafayette Ave.

19 (a) DEC 16 1944 (Date received by Registrar) (b) Huntington Woodlawn, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1944, at 4 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to 12-14 1944 and that I last saw her alive on 12-14 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day

Due to: Arterial Hypertension — Duration: 6 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. W. Peake M. D.

Address 4508 Hereford Rd Date signed 12-15 1944

VS 150

669531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 669531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Memorial Hosp.
(c) Hospital or institution: 33rd & Calvert Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (17)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 W. Mosher St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hanford Joel Moffett.

3 (b) If veteran, name war W. W. #1

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Elizabeth L. Moffett.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27th 1887

8. AGE: Years	Months	Days	If less than one day
61	1 X	17 X	hr. min.

9. Birthplace New Jersey
(Town, county, and state)

10. Usual Occupation Surveyor (Balt. City)

11. Industry or business

FATHER
12. Name Hanford Moffett
13. Birthplace New York

MOTHER
14. Maiden name Harriett Crozden
15. Birthplace New York

16 (a) Informant Elizabeth L. Moffett
(b) Address 121 Mosher St

17 (a) Burial (Burial, ~~cremation, or removal~~) **(b) Date thereof** 12/17/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) DEC 17 1948 (Date rec'd by registrar) **(b)** Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1948, at 12 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1948 to Dec. 14 1948 and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary occlusion,	
Due to Coronary arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: no above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin P. Moore

Address Union Memorial Hosp. Date signed 12/14/48 M.

VS 150

G69532 DC-48-26940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G69532

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18-
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1038 Sarah (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 | 12 | 48

8. AGE: Years	Months	Days	If less than one day
Newborn			2 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Lillian Washington
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 16 1948

18 (a) Funeral director Commissioner of Health,
(b) Address

19 DEC 17 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1948, at 10.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1948 to Dec 10 1948, and that I last saw h er alive on Dec 10 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Atelectasis	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. C. Hunter M.D.
Address Univ. Hosp. Date signed 12-10-48 M. D.

VS 150

669533 BC-48-26408 ✓ 669533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 W Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby boy Russell

3 (b) If veteran, name war	3 (c) Social Security Account No.
∅	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/7/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jack Russell
13. Birthplace Portsmouth - Virginia

MOTHER
14. Maiden Name Virginia Hattie Jones
15. Birthplace Norfolk, Virginia

16 (a) Informant Hattie
(b) Address 709 West Lexington St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 13 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) DEC 17 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1948, at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1948 to Dec 8 1948 and that I last saw h[illegible] alive on Dec 8 1948.

Immediate cause of death	Duration
Atelectasis	Life
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blackburn S. Jones, M.D.
Address Univ. Hosp. Date signed 12/8/48

Redwood Clinic

VS 150

G69534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 378

Registered No. G69534

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway at Fremont
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore Edgemere
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Ritchie Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Isabell Jane Devore

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Mr. W. C. Devore
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1898

8. AGE: Years	Months	Days	If less than one day
50	10	20	hr. min.

9. Birthplace Chester County, Pa
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr. Thomas Caldwell
13. Birthplace Ireland

MOTHER
14. Maiden Name ? Strauss
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18 1948 (month) (day) (year)
(c) Cemetery or crematory Morelands
Location Taylor Ave
18 (a) Funeral director Leo G. Crook
(b) Address 1701-03 N. Patterson Park Ave
19 (a) DEC 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14/48 19 at 4:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1948 to Dec 14 1948, and that I last saw her alive on Dec 14 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to - Bronchopneumonia	
bilateral	
Due to - Post encephalitic Parkinsonism	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: D W Mentzer M.D.
Address Church Home & Hosp. Date signed 12/15/48

VS 150

G69535 BC-48-19348

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G69535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Streets
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 19 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos. 19 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Joyce Parker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 10th 48

8. AGE: Years	Months	Days	If less than one day
—	2	19 29	hr. min.

9. Birthplace Baltimore, Baltimore, Md. (town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name William Parker
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Parker
15. Birthplace S. Ca. Julia

16 (a) Informant Mother (Julia Parker)
(b) Address 1230 W. Lanvale St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 13 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) DEC 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7/1948 at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20/1948 to 12/7/1948. and that I last saw HER alive on 12/7/1948

Immediate cause of death	Duration
Cardiac + respiratory failure	
Due to Cerebral anoxia	12 hrs.
Due to Transfusion reaction (?)	
Other Conditions Prematurity (7 mos.)	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Pheneuf Jr. M. D.
Address University Hosp. Date signed 12/9/48

669536 B.C. 48-27119

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160a

669536 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy WATKINS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/7/48

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Florence Watkins
15. Birthplace Md.

16 (a) Informant Florence Watkins
(b) Address 411 N. Fremont Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 14 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12-1948, at 9:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1948, to 12-11 1948, and that I last saw him alive on 12-11 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Trauma, Labor, Delivery	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Univ. Hosp. Date signed

VS 150

669537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669537

LCH-125355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Camp Holabird Qtrs. 93 (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH HUBBARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marjorie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/19/17

8. AGE: Years	Months	Days	If less than one day
31	9	24	hr. min.

9. Birthplace Ark. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Hubbard
13. Birthplace Ark.

MOTHER
14. Maiden Name Grace Sanders
15. Birthplace Ark.

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12 17 48 (month) (day) (year)
(c) Cemetery or crematory Benton Funeral home
Location Forydce, Arkansas

18 (a) Funeral director Lilly & Zeiler, Inc
(b) Address 403 S. Wolfe Street

19 DEC 17 1948 (Date rec'd by registrar) (b) Frontis Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/48 19 , at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15/48 19 , to 12/15/48 19 , and that I last saw him alive on 12/15/48 19 .

Immediate cause of death	Duration
Spontaneous subarachnoid hemorrhage.	12 hrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vinton M.D.
Address Balto City Hosp Date signed 15 Dec 48

V S 150

669538

CERTIFICATE CORRECTED 9-1-60

JL - 111969 -

CERTIFICATE OF DEATH

937

669538

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 S. Durham St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Schaefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1870 1870

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Conrad Schaefer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Chris
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/18/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Tully & Zagb
(b) Address 403 S. Eutaw St.

19 (a) DEC 17 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1948, at 5AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7- 1948 to Dec. 14 1948, and that I last saw him alive on Dec. 14 1948

Immediate cause of death
CARDIAC FAILURE & BRONCHOPNEUMONIA — Duration: 1 WEEK

Due to
ARTERIOSCLEROTIC HEART DISEASE — Duration: ?

Due to & GENERALIZED ARTERIOSCLEROSIS — Duration: ?

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: NONE

of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jennings M. D.
Address BALTIMORE CITY HOSP. Date signed 12-16-48

V S 190

669539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 669539

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 S. Newkirk St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 S. Newkirk St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Neimiller

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-1979

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	married

6 (b) Name of husband or wife Margaret Baumer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/12/1888

8. AGE: Years	Months	Days	If less than one day
60	7	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business H. P. Davis Co.

FATHER
12. Name Wm. Neimiller
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Schreiner
15. Birthplace Md.

16 (a) Informant Dora Neimiller
(b) Address 416 S. Newkirk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Lilly & Gaul
(b) Address 403 S. Charles St

19 (a) DEC 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Dec. 1948 at 6:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner.
Date signed 15 Dec. 1948

VS 151

G69748 Estate Papers

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. G69540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 W 38th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 W 38th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Thomas Hare

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 3, 1871

8. AGE: Years	Months	Days	If less than one day
77	3	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Hare
13. Birthplace Maryland.

MOTHER
14. Maiden Name Maria Morrison
15. Birthplace Maryland.

16 (a) Informant Mrs. Maybelle A. Shaffer
(b) Address 1020 W 38th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto Co. Md.

18 (a) Funeral director Austin C. Donovan
(b) Address 3638 Roland Ave.

19 (a) Dec 17 1948 (Date received by local registrar) (b) Austin C. Donovan, Funeral Director

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8/48 19__ to 12/14/48, and that I last saw him alive on 12/14/48.

Immediate cause of death	Duration
Acute Coronary Thrombosis	Sudden
Due to Chr Endocarditis	Long
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Lemmon M.D.
Address 1901 Eutaw Place, City Date signed 12/16/48

VS 150

669541 AB-124347

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 669541

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 1mo. ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Aliceann Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Ratczak (Or) Valintyna B. Ratajczak

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-6397

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	? Widow

6 (b) Name of husband Michael Ratajczak
6 (c) If alive, give age dec'd years

7. Birth date of deceased (mo., day, yr.) ?-?-?

8. AGE: Years	Months	Days	If less than one day
72 ?			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Record-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-48 (month) (day) (year)
(c) Cemetery ~~xxxxxxx~~ St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) DEC 17 1948 (Date rec'd by registrar) (b) Huntingtown Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16- 1948, at 11.22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5- 1948. to 12-16- 1948., and that I last saw her alive on 12-16- 1948.

Immediate cause of death Arteriosclerotic heart disease — Duration

Due to Generalized arterio-sclerosis — yrs

Due to

Other Conditions Gangrene L. foot

(Include pregnancy within 3 months of death)

Date of operation 11-28-48

Major findings of operations: Gangrene L. foot

of autopsy: Board

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dyke A Pitsford MD M. D.
Address 4940 Eastern Ave Date signed 12-16-48

V S 150

G69542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G69542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Reed Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Bielasky

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) June 2, 1885

8. AGE: Years 63 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Europe (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name John Shutak
13. Birthplace Europe

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Louise Krysiak
(b) Address 516 Bayside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd

18 (a) Funeral director John F Kenny Inc
(b) Address 1117 Light St

19 DEC 17 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1948, at 1:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14, 1948 to Dec. 17 1948, and that I last saw h[illegible] alive on Dec 14 1948.

Immediate cause of death	Duration
Acidosis	
Due to Diabetes Mellitus	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marion C. Insley, Jr. M.D.
Address 1213 Light St. Date signed Dec. 17 1948

VS 150

G69543 ✓ G69543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1125 CARROLL ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 CARROLL ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA M. ROSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6 (b) Name of husband ~~or wife~~ Pete W H H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 16 1877

8. AGE: Years	Months	Days	If less than one day
71	4	0	hr. min.

9. Birthplace BALTO. MD
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name BEINE
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARGARET
15. Birthplace GERMANY

16 (a) Informant MRS THELMA M GROSS
(b) Address 1912 E 28th ST

17 (a) BURIAL (b) Date thereof DEC. 18 '48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry H. Withe
(b) Address 4101 EDMONDSON AVE

19 (a) DEC 17 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 16 1948 at 11 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 JUNE 1929 to 16 DEC 1948.
and that I last saw h[illegible] alive on 15 DEC 1948.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	20 DAYS
Due to ARTERIOSCLEROSIS	9 YRS
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: NO
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward T. Nolan M.D.
M. D.
Address 682 W Lafayette Ave Date signed 17 Dec 48

VS 150

X

G69544 ARIGO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. G69544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Calhoun Sts

(c) Hospital or institution: Franklin Square Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1307 W. Fayette St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Thomas Arigo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1879

8. AGE: Years 69 | Months 7 | Days 13 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Father Healy

(b) Address St. Martins Rectory

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14 41 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 3800 Old Frederick Rd

18 (a) Funeral director Harry N. Wilkes

(b) Address 410 Edmondson Ave.

19 (a) DEC 17 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1948 at 8.45 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1948 to 12/16 1948 and that I last saw h[illegible] alive on 12/16 1948

Immediate cause of death	Duration
Bronchopneumonia entire R. Lung.	
Due to Bilateral pleurisies	
Due to Biliary cirrhosis following Common duct exploration.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12/4/48

Major findings of operation: Common duct stone &

of autopsy: Bronchopneumonia etc.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Fred Hawkins Jr M.D.

Address Franklin Square Hosp Date signed 12/16/48

VS 153

669545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

669545 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard Sts.
(c) Hospital or institution: University Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 N. Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Anna Crout

3 (b) If veteran, name war	3 (c) Social Security Account No.
D	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John E. Crout
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 10, 1896

8. AGE: Years	Months	Days	If less than one day
52	2	5	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Richard Warner
13. Birthplace Md.

MOTHER
14. Maiden Name Magdelina ------
15. Birthplace Md.

16 (a) Informant John E. Crout
(b) Address 821 N. Augusta Ave.

17 (a) Burial (b) Date thereof Dec. 18/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. & Longwood St.

18 (a) Funeral director Harry H. Luitzke
(b) Address 4101 Edmondson Ave.

19 (a) DEC 17 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 15 1948, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 1948 to 12-15 1948, and that I last saw h alive on 12-15 1948.

Immediate cause of death
Coronary thrombosis
Due to Pneumatic fever
Due to Cardiac failure
Other Conditions Art. sclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard E. Hall M. D.
Address Univ. Hosp. Date signed 12-15-48

VS 150

G69546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G69546

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3824 Garrison Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3824 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM T. CHILDS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Minnie V. Childs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1868

8. AGE: Years	Months	Days	If less than one day
80	10	14	hr. min.

9. Birthplace Howardville, Mo.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Childs
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. William R. Childs
(b) Address 4407 Marble Hall Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1948, at 10:00 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 nd 1948 to Dec 16th 1948, and that I last saw h[illegible] alive on Dec 16th 1948.

Immediate cause of death	Duration
Heart Failure	24 hrs
Due to Myocarditis	1 year
Due to Arteriosclerosis Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. L. Poulton, M.D.
Address 394 Edmondson Blvd. Date signed 12/17/48

VS 150

669-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

669-47 Registered No.

PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3060 Mayfield ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Josephine Mares

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Anton Mares
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1873

8. AGE: Years	Months	Days	If less than one day
75	9	7	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER
12. Name Mary Kvap
13. Birthplace Czechoslovakia

FATHER
14. Name James Mlady
15. Birthplace Czechoslovakia

16. (a) Informant Mrs. Josephine Mares
(b) Address 3060 Mayfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-05 E. Madison St. Balto. Md.

19 (a) DEC 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1948 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1948 to Dec 14 1948.
and that I last saw her alive on Dec 14 1948.

Immediate cause of death Cachexia & toxicity — Duration Fatal.

Due to Fecal fistula — 17 days

Due to Carcinoma of Ovary — Indefinite

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov. 16, 1948

Major findings of operation: Carcinoma of ovary & adhesions

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. Robert Haase M. D.
Address Church Home & Hosp. Date signed

VS 150

Dec 14, 1948

G69548 Mbg 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G69548

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Quito (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 San Salvador (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Ecuador

3 (a) FULL NAME Carmen Martinez Ponce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-18-20

8. AGE: Years	Months	Days	If less than one day
28	4	28	hr. min.

9. Birthplace Ecuador (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alfredo Martinez
13. Birthplace Ecuador

MOTHER
14. Maiden Name Carmen Espinosa
15. Birthplace Ecuador

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/17/48 (month) (day) (year)
(c) Cemetery or crematory Quito, Equator. South America.
Location

18 (a) Funeral director Schimunek Funeral Home Inc.
(b) Address 2601-03-05 E. Madison Street

19 DEC 17 1948 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15 1948, at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1948 to 12-15 1948, and that I last saw her alive on 12-15 1948.

Immediate cause of death: Uremia — Duration: Unknown / 1 week

Due to: Pyelonephritis, acute, due to Coli aerogenes

Due to: Glomerulonephritis, chronic

Other Conditions: Lupus erythematosus, disseminated, (include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Shull M. D.
Address Johns Hopkins Hospital Date signed Dec. 15, '48

VS 150

669549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

669549 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 1359 Ward St.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1359 Ward St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Medelia Phillips

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	colored	married

6 (b) Name of husband or wife William R. Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years	Months	Days	If less than one day
90			hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation House work
11. Industry or business

FATHER 12. Name	Richard Spellman
FATHER 13. Birthplace	Sweden N. Carolina
MOTHER 14. Maiden Name	Mary Boston
MOTHER 15. Birthplace	North Carolina

16 (a) Informant Robert Henry Phillips
(b) Address 45 E. 31st. New York.

17 (a) (Burial, cremation, or removal) (b) Date thereof 12-17-48 (month) (day) (year)
(c) Cemetery or crematory Hook Folk Va.
Location

18 (a) Funeral director Walter D. Snipp
(b) Address 139 Wittamley St.

19 DEC 17 1948 (Date rec'd by registrar) (b) Huntington West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14-48 1948, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1948 to 12-14 1948, and that I last saw h[illegible] alive on 12-14 1948.

Immediate cause of death Chronic Myocarditis
Myocardial degeneration
Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration 2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich Jr. M. D.
Address 127 N Wash Blvd Date signed 12-16-48

VS 150

669550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

669550 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4006 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 Falls Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter (WILLIAM) ELLWORTH HENRY

3 (b) If veteran, name war ---

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Fannie L. Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1882

8. AGE: Years	Months	Days	If less than one day
66	4	21	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business B & O Railroad

FATHER
12. Name Aaron Henry
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Boone
15. Birthplace Maryland

16 (a) Informant: Mrs. Elsie M. Brown
(b) Address 3104 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co., Maryland

18 (a) Funeral director BURGEE FUNERAL HOME
(b) Address 3631 Falls Road

19 (a) DEC 17 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1948, at 8:30 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Pearson M.D.
Medical Examiner.
Date signed 12-16-48

VS 151

X

G69551

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

Registered No. G69551

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1242 Sharp Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERALDINE (ESTELLE) FLOYD (BARNES)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Baltimore, Mryland
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Emanuel Floyd
13. Birthplace Virginia

MOTHER
14. Maiden Name Helen Murray
15. Birthplace Baltimore, Maryland

16 (a) Informant: Mary Askew
(b) Address 1421 Mosher Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Balto Md

18 (a) Funeral director WILLIAM A. JACKSON
(b) Address 916 Penna Ave

19 DEC 17 1948 (Date received by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1948, at 8:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet wounds of Cranial cavity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-9-48 at 7:45 P. M.
(b) Where did injury occur? 1242 Sharp Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Firearms

23. Signature Earl R. Royster M.D.
Medical Examiner
Date signed 12-10-48

VS 151

669552

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 307

Registered No. 669552

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1225½ Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BERTIE BLACK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Waylie Black

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 31, 1900

8. AGE: Years	Months	Days	If less than one day
48	8	14	hr. min.

9. Birthplace Blackstone, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Norman Epps
13. Birthplace Va.

MOTHER
14. Maiden Name Lettee Thomas
15. Birthplace Va.

16 (a) Informant Dollie Stokes
(b) Address 1219 Owings Pl. N.E. Washington, D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/48 (month) (day) (year)
(c) Cemetery or crematory Mt Nebo
Location Blackstone Va

18 (a) Funeral director Wm A Jackson
(b) Address 916 Edna Ave

19 (a) DEC 17 1948 (Date rec'd by registrar) (b) Transit to Williamsburg, Va

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 14 1948 at 1:10 P.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Subacute bacterial endocarditis.
Syphilitic aortitis and aortic valvulitis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Geo. G. Merrill M.D. Medical Examiner.

Date signed 12/14/48

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D

G69553
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Madison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Adirana Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name Richard Robinson
13. Birthplace Virginia

MOTHER
14. Maiden Name Jennie Fooks
15. Birthplace Virginia

16 (a) Informant Adirana Robinson
(b) Address 1229 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director WILLIAM A. JACKSON
(b) Address 916 Penna Ave

19 (a) DEC 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 19 48, at 11:45PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration
Luetic aortitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work
(d) Means of injury

23. Signature Medical Examiner, M.D.
Date signed 12-16-48

VS 151

G69554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G69554

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E Monument & St.
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2535 Quantico (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 73 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county and state or country)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Sunoy
13. Birthplace Russia

MOTHER — 14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Sara Kleger
(b) Address 2535 Quantico Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) DEC 17 1948 (Date received by registrar)

Registrar Huntington Williams, M.D.

CERTIFICATION APPROVED BY M. Cullen M.D. CHIEF OR ASST. MEDICAL EXAMINER

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1948 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1948 to 12-16 1948 and that I last saw her alive on 12-16 1948

Immediate cause of death Pulm. edema — Duration

Due to cardiac decompensation

Due to ASHD

Other Conditions uremia; diabetes; fract. hip; pos. ca trans. (Include pregnancy within 3 months of death)

Date of operation 11-21-48

Major findings of operation:

fract. hip

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/13
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence April 13 1948 at 7 M
(c) Where did injury occur? 2535 Quantico Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At Home (Specify type of place) While at work? No
(e) Means of injury Slipped while getting out of bed.

23. Signature Ben K Silverman

Address Sinai Hosp. Date signed 12-16-48 M.D.

VS 150

X

G69555 Bur 3

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52a

Registered No. G69555

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Massi Von (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Neale Ave S.W. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Italy

3 (a) FULL NAME Michael Cardinal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Male	White	Married

6 (b) Name of husband or wife Josephine
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 7-20-93

8. AGE: Years	Months	Days	If less than one day
55	4	28	hr. min.

9. Birthplace Italy (Town, county and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Lawrence Cardinal
13. Birthplace Italy

MOTHER
14. Maiden Name Antoinette Ambrossio
15. Birthplace Italy

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/48 (month) (day) (year)
(c) Cemetery or crematory
Location Massillon, Ohio
18 (a) Funeral director John O. Mitchell & Sons.
(b) Address 800 Eutaw Place
19 (a) DEC 21 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17- 1948 at 4 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9- 1948 to 12-17 1948 and that I last saw him alive on 12-17 1948

Immediate cause of death Hypernephroma — Duration
Due to Carcinomatosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Dec 15, 1948
Major findings of operation: Hypernephroma & carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R A Kelly
Address Johns Hopkins Hosp Date signed 12-17-48

VS 150

Caution: Entries must be complete, with no blanks. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669556 Mbg 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 669556

Typing or writing in PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4608 Roland Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Terry Burger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis J. Burger
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) 9-18-73

8. AGE: Years	Months	Days	If less than one day
75	3	29	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wilbur F. Terry
13. Birthplace Md

MOTHER
14. Maiden Name Josephine A. Rogers
15. Birthplace Md

16 (a) Informant Louis J. Burger
(b) Address 4608 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3601 Frederick Ave

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1919 Eastern Place

19 (a) DEC 17 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16/48 (day) (year) at 1.37 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9/1948, to 12/16/1948, and that I last saw her alive on 12/16/1948.

Immediate cause of death myocardial infarction — Duration

Due to coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Grant Wilson M.D.
Address Johns Hopkins Hosp. Date signed 12/16/48

X

G69557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69557

The following items must be carefully supplied. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1067 W Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1067 W Lexington St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Jennings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mary Jennings
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1876

8. AGE: Years	Months	Days	If less than one day
70	2	26	hr. min.

9. Birthplace A A Co Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name David Jennings
13. Birthplace A-A Co Md

MOTHER
14. Maiden Name Katie Wing
15. Birthplace A A Co Md

16 (a) Informant Mary Jennings
(b) Address 1067 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) DEC 17 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1948, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1946 to Dec 13 1948 and that I last saw him alive on Dec 13 1948.

Immediate cause of death	Duration
Coronary Vascular Disease	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E William Frey
Address 1928 Penna Ave Date signed 12/15/48

VS 150

G69558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69558

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5011 Gwynn Oak Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 71

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5011 Gwynn Oak Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Catherine Elizabeth Meinl (Catherine Elizabeth Meinl)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Joseph A. Meinl

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Dec 22 - 1876

8. AGE: Years	Months	Days	If less than one day
71	11	23	24 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

FATHER
12. Name John Lehr
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Euler
15. Birthplace Baltimore Md

16 (a) Informant Jos. Meinl
(b) Address 5011 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18, 1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Phillis Lamonaco
(b) Address 4510 Liberty Heights Ave.

19 (a) Dec 17 1948 (b) Arrington Williams Md
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1948, at 1010 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1938, to Dec 15 1948, and that I last saw h alive on Dec 15 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	9/18/48
Due to Hypertension	1938
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brown

Address 1663 W. North Ave, Date signed 12/16/48 M. D.

VS 150

Paul Brown X

The G69559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G69559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts
(c) Hospital or institution:
Hospital For the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 Mohawk Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rogers, Vessie (Jessie M. Rogers)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Charles G. Rogers deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1892

8. AGE: Years	Months	Days	If less than one day
56	8	3	hr. min.

9. Birthplace Franklin, Georgia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name ~~Wood, William~~ Wyatt Wood
13. Birthplace Newnan, Georgia

MOTHER
14. Maiden Name ~~Olivia~~ Daniels, ~~Olivia~~
15. Birthplace ? Georgia

16 (a) Informant Pt. Mr. Charles G. Rogers
(b) Address 3600 Mohawk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Willis Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) DEC 17 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1948, at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1948 to Dec. 16 1948 and that I last saw her alive on Dec. 16 1948

Immediate cause of death	Duration
Carcinomatosis	
Due to Carcinoma breast	Two yrs.
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: Complete —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eben T. Bennet M. D.
Address Hosp. for Women of Md. Date signed Dec. 16 1948

VS 150

X

G69560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69560

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 Marshall St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Marshall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie C. Curley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced W.

6 (b) Name of husband or wife Edward J. Curley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12-1866

8. AGE: Years 82 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name John T. Gregory
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Frances Carroll
15. Birthplace Dorchester Co. Md.

16 (a) Informant John W. Dunn
(b) Address 4707 Shamrock Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-48 (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 DEC 17 1948 (Date rec'd by registrar) (Registrar) Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16/48 19 . at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1948 to Dec 16 1948 and that I last saw h alive on Dec 16 1948

Immediate cause of death Uremia
Due to Pneumonia
Due to
Other Conditions Senility Chronic myocarditis
(Include pregnancy within 3 months of death)

Duration: 1 week

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M.D. M. D.
Address 122 E. Clay Date signed 12/17/48

VS 150

109a 12/17/48

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A669561 B.C.48-27044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 669561

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 North Charles St.
(c) Hospital or institution:
Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (parents) 723 Carroll St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Burris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-10-48

8. AGE: Years	Months	Days	If less than one day
		3 2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Marvin Gerald Burrus
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Betty Irene Sperrow
15 Birthplace Martinsburg, W. Va.

16 (a) Informant father & mother
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 18 48 (month) (day) (year)
(c) Cemetery or crematory Martinsburg W. Va.
Location

18 (a) Funeral director Thomas J. Kemp Jr.
(b) Address 1 Holland st

19 (Date rec'd by registrar) DEC 17 1948 Herbert Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1948 19 , at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10-48 19 , to 12-12-48 19 , and that I last saw him alive on 12-12-48 19 .

Immediate cause of death Cranial Hemorrhage — Duration —
Due to Congenital — —
Due to — —
Other Conditions — —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Louis H. Fagin M. D.
Address 716 Walbrook Bldg Date signed

VS 159

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G69562

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Ann. Convent 2209 Greenmount Ave
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Warfield

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F.
5. Color or race: Negro Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Caleb Warfield deceased
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 14, 1898
8. AGE: Years 50 | Months 10 | Days 1 | If less than one day: hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Austin Morris
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Charles M. Warfield
(b) Address 1303 Montello Ave Wash D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18, 1948 (month), (day), (year)
(c) Cemetery or crematory St. Louis Cem.
Location Clarksville, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (a) DEC 17 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1948 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1948 to Dec. 15 1948 and that I last saw her alive on Dec. 15 1948.

Immediate cause of death	Duration
Acute Coronary Thrombosis	
Due to Arteriosclerosis, Generalized	
Due to Hypertensive Cardiovascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Acute coronary thrombosis Chronic glomerulonephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Willis Baker Jr. M.D.
Address St. Joseph's Hospital Date signed 12-15-48

VS 150

G69563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G69563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3034 Belmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3034 Belmont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Christopher Lilly

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-1969

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Mary Virginia Lilly
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Nov. 21-1872

8. AGE: Years	Months	Days	If less than one day
76	-	23	hr. min.

9. Birthplace Baltimore City (Town, county, and state)
10. Usual Occupation Retired night watchman
11. Industry or business J. Roy & Co

FATHER
12. Name William J. Lilly
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Mary E. DeSweese
15. Birthplace Harford Co. Md.

16 (a) Informant Mrs. Mary V. Lilly
(b) Address 3034 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Easton Sons
(b) Address Catonsville, Md.

19 (a) DEC 17 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1948, at 11:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1948 to Dec. 19 1948, and that I last saw h alive on Dec. 13 1948.

Immediate cause of death	Duration
Coronary Thrombosis	12/19/48
Due to Hx. Myocarditis	1942
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Brown M.D.
Address 1663 W. North Ave Date signed 12/20/48

VS 150

669564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46H

Registered No. 669564

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Manassas (If outside city or town limits, write RURAL and give town)
(d) Street No. PO Box 204 (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME STEVEN JOHNSON LEWIS, JR.

3 (b) If veteran, name war --

3 (c) Social Security Account No. 027-12-5104

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1923

8. AGE: Years 25 Months 3 Days 21 If less than one day hr. min.

9. Birthplace Harrisburg, Pa. (Town, county, and state)

10. Usual Occupation Radio Operator

11. Industry or business Seafarer

FATHER
12. Name Steven J. Lewis, Sr.
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Howard
15. Birthplace DC

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/17/48 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location

18 (a) Funeral director Robert G. Sindlinger
(b) Address 820-7 St, NW. - Wash D.C.

19 (a) DEC 17 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1948, at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1948 to Dec. 17 1948, and that I last saw him alive on Dec. 17 1948.

Immediate cause of death Mesothelioma with generalized metastases — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 12/17/48

VS 180

G69565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. G69565

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cecil
(c) City or town Charlestown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marcel Cather

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Married

6 (b) Name of husband or wife Anna Cather
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1883

8. AGE: Years	Months	Days	If less than one day
65	3	11	hr. min.

9. Birthplace Cecil Co. Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Samuel Cather
13. Birthplace Cecil Co. Md.

MOTHER
14. Maiden Name Mary Physic
15 Birthplace Cecil Co. Md

16 (a) Informant Anna Cather
(b) Address Charlestown, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Charlestown
Location Charlestown, Md

18 (a) Funeral director Wm. A. Patterson & Son
(b) Address Perryville, Md.

19 (a) DEC 18 1948 (Date received by local registrar) (b) Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Dec. 1948 at 8:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Dec 1948 to 17 Dec 1948 and that I last saw h[illegible] alive on 17 Dec 1948.

Immediate cause of death	Duration
Coll. Op Atelectasis	
Due to Op. for resection of Esophagus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 16 Dec
Major findings of operation: Carcinoma of Esophagus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. E. Cranmore M. D.
Address Maryland Gen'l Hosp. Date signed 17 Dec 48

VS 150

X

669566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 939

Registered No. 669566

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2834 N. Calvert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harmon Lewis Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-4705

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jeanette Lowe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28th 1878

8. AGE: Years	Months	Days	If less than one day
70	0	18	hr. min.

9. Birthplace Pa
(Town, county, and state)
10. Usual Occupation Home Decorator
11. Industry or business

FATHER
12. Name Samuel Freeman
13. Birthplace Pa.

MOTHER
14. Maiden Name Sophia Paine
15. Birthplace Pa.

16 (a) Informant Mrs. Jeanette L. Freeman
(b) Address 2834 N. Calvert St.

17 (a) Burial (b) Date thereof 12/18/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 18 1948 (b) Lundington for Williamsburg M.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16th 1948, at 6a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946 to Dec-16 1948. and that I last saw h[im] alive on Dec. 16 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	5 days
Due to Arteriosclerotic Cardio-Vascular Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilbur N. Foster M.D.
Address 11 E. Chase St. Date signed 12-17-48

VS 150

G69567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G69567

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town Hornell (If outside city or town limits, write RURAL and give town)
(d) Street No. 58 Jane St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Baird

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-1-47

8. AGE: Years	Months	Days	If less than one day
1	4	16	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Baird
13. Birthplace N. Y.

MOTHER
14. Maiden Name Dorris Egger
15. Birthplace N. Y.

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial, cremation, or removal (b) Date thereof 12/18/48 (month) (day) (year)
(c) Cemetery or crematory St Anns
Location Hornell N. Y.

18 (a) Funeral director Fulton & Dye
(b) Address 1217 E Fond St

19 (a) DEC 18 1948 (b) Huntington Williams M.D.
Date received by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1948, at 3 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3 1948 to 12-17 1948, and that I last saw her alive on 12-12 1948.

Immediate cause of death: Cardiac Decompensation — Duration

Due to: Post operative 5 hrs.

Due to: Decompensation of Heart

Other Conditions: Bed Sores & Heart (Include pregnancy within three months of death)

Date of operation Dec 17, 1948

Major findings of operation: Same

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D D Easley M. D.
Address The Johns Hopkins Hospital Date signed Dec 17 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69568 Hospital Disposal B.C. 48-28757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G69568

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5242 Saint Thomas Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Jefferson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-13-48

8. AGE: Years	Months	Days	If less than one day
			8 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Milton H. Jefferson
13. Birthplace Md.

MOTHER 14. Maiden Name Audrey Smith
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) DEC 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1948, at 5 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13-1948 to 12-13-1948 and that I last saw her alive on 12-13-1948.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ed. Goldstein M. D.
Address J. Hopkins Hosp. Date signed 12/15/48

VS 159

G69569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B.C.H.-10836 107

Registered No. G69569

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas White Clemmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race C.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1948

8. AGE: Years | Months 6 | Days | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Clemmons
13. Birthplace N. C.

MOTHER
14. Maiden Name Lilly White
15. Birthplace N. C.

16 (a) Informant Lilly White Clemmons
(b) Address 1317 N. Bond St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-18-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Locke Jr.
(b) Address 1304 N. Central Ave

19 DEC 18 1948 (Date rec'd by registrar) (Signature of Registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17 1948 at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1948 to 12-17 1948 and that I last saw h— alive on 12-17 1948

Immediate cause of death

Due to Broncho-Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. F. Leary M. D.

Address 1420 E. Chase Date signed 12-17-48

VS 150

G69570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G69570

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 North Edenst
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Peterson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-18-80

8. AGE: Years	Months	Days	If less than one day
68	3	28	hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Wade Peterson
13. Birthplace S.C.

MOTHER
14. Maiden Name Martha James
15. Birthplace S.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec. 18-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Blankley ave Huntington Station, Md

19 (a) DEC 18 1948 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1948, at 10 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1948 to 12-15 1948 and that I last saw h alive on 12-15 1948.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Syphilitic Aortitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. McMillinkoff M. D.
Address Johns Hopkins Hosp Date signed 12/20/48

VS 150

937

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G69571

LCH-124806

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G69571

Type or write with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Eagle Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY LUTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Mattie S. Mason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/10/1888

8. AGE: Years	Months	Days	If less than one day
60	1	5	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Lutz (d)
13. Birthplace Germany

MOTHER
14. Maiden Name Rebecca Staugh (d)
15. Birthplace Pa.

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lanvale St.

DEC 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/48 19 , at 10:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23/48 19 , to 12/13/48 19 , and that I last saw him alive on 12/13/48 19 .

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to ARTERIOSCLEROTIC HEART DISEASE	
Due to CEREBRAL THROMBOSIS	3 WEEKS
Other Conditions CARDIC BRONCHITIS	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: NONE
of autopsy: AS ABOVE (BRAIN NOT DONE)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jennyon M. D.
Address BALTIMORE CITY HOSP. Date signed 12-16-48

V S 150

G69572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G69572

The following information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3315 Alameda Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Harry Kammerer

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Widowed

6 (b) Name of husband or wife Hermoyne B. Ulbig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1878

8. AGE: Years	Months	Days	If less than one day
70	8	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation ~~None~~ Druggist
11. Industry or business Retired

FATHER
12. Name William A. Kammerer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15 Birthplace Baltimore, Md.

16 (a) Informant William H. Kammerer
(b) Address 3315 Alameda Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St

19 (a) Filed DEC 22 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1948 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12, 1948 to Dec. 15, 1948 and that I last saw him alive on Dec. 15, 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Arteriosclerosis Arteriosclerotic	
~~Due to~~ Cardiovascular Disease	
Diabetes Mellitus	
~~Other Conditions~~ Diabetic Gangrene	
Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Bahnsen M.D.
Address St. Joseph's Hospital Date signed 12-15-48

VS 150

669573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164 E

Registered No. 669573

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 229 Lambert Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 Lambert Road
(If rural give location)
(e) Citizen of foreign country? Lambeth (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES (EDDOO) EDOO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	West Indian	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1875

8. AGE: Years	Months	Days	If less than one day
73	-	16	hr. min.

9. Birthplace East Indies (Town, county, and state)
10. Usual Occupation Butler
11. Industry or business

FATHER
12. Name Edoo
13. Birthplace West Indies

MOTHER
14. Maiden Name Unknown
15. Birthplace West Indies

16 (a) Informant Dr. J. Bergland
(b) Address 229 Lambith Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director MRS. FRANCES A. HEMSLEY
(b) Address 578 W. Biddle Street

19 DEC 18 1948 (Date rec'd by registrar) (Signature for Williams, M.D.) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1948, at 7 A. M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-16-48 at 6:30 A. M.
(b) Where did injury occur? 229 Lambert Road
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Jumped from third story window

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12-16-48

669574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. 669574

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2727 Tivoly Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 Tivoly Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET M. GOEB

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Henry Goeb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1895

8. AGE: Years	Months	Days	If less than one day
53	8	16	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Martha Hunt
15. Birthplace Maryland

16 (a) Informant Henry Goeb
(b) Address 2727 Tivoly Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 15 48 (month) (day) (year)
(c) Cemetery or crematory Lorrain
Location Winsor Mill Road

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Filed 31

19 (a) DEC 18 1948 (Date received by Registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1948, at 5.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1948 to Dec 14 1948, and that I last saw her alive on Dec 14 - 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Mitral Regurgitation	1 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac L. Dickson M. D.
Address 305 W. North ave Date signed Dec 18-48

VS 150

669575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

669575 Registered No.

The following items must be carefully supplied. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 E. 33rd St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 E. 33rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Dr. Sparks

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Leah Z. Sparks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 20, 1868

8. AGE: Years	Months	Days	If less than one day
80	0	27	hr. min.

9. Birthplace Patapsco Neck, Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Farmer - retired
11. Industry or business

FATHER
12. Name John Wesley Sparks
13. Birthplace Salem Co., N. J.

MOTHER
14. Maiden Name Mary Way
15. Birthplace Harford Co., Md.

16 (a) Informant Mrs. Leah Z. Sparks
(b) Address 825 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.,
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1948, at 4:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1932 to Dec 17 1948 and that I last saw h alive on Dec 16 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Harper Towell M. D.
Address 1045 N. Madison Date signed Dec 17, 48

VS 153

X

G69576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G69576

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3504 Edgewood Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Edgewood Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM M. McLean

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Isabel McLean

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1894

8. AGE: Years: 54 Months: Days: 20 If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Superintendent

11. Industry or business: Gas & Electric Company

FATHER
12. Name: David McLean
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Sarah Laughlin
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mr. William S. McLean
(b) Address: 3504 Edgewood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cemetery
Location: Pikesville, Maryland

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: Baltimore, Maryland

19 (a) DEC 18 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1948, 8.30a.M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Kaylor M.D.
Medical Examiner.
Date signed December 17, 1948

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69577 BALTIMORE CITY HEALTH DEPARTMENT G69577
Registered No.

CERTIFICATE OF DEATH

200 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Woods: 3100 Blk. Sun Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES FERRY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1895

8. AGE: Years 53 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name Charles Ferry
13. Birthplace Ireland

MOTHER
14. Maiden Name Buga Logue
15. Birthplace Ireland

16 (a) Informant Joseph J. Milligan
(b) Address 1346 South 29th Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-18-48 (month) (day) (year)
(c) Cemetery or crematory
Location Philadelphia, Pa.

18 (a) Funeral director THOMAS J. KENNY, INC.
(b) Address 1600 Hollins Street

19 (a) DEC 18 1948 (Date rec'd by registrar) (b) Beatrice for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1948, at 2:00PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Undetermined

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 25/6
(a) Date of injury Found: 12-9-48 at 2:00 P. M.
(b) Where did injury occur? Found: 3100 Blk. Sun St.
(c) Did injury occur at home, on farm, industrial place, in public place? Woods While at work? No
(d) Means of injury Found dead

23. Signature George F. Merrill M.D.
Medical Examiner.
Date signed 12-18-48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

B.C. 48-27484

669578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G69578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins avenue
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 ½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County Baltimore
(c) City or town Ilchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Givens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/17/48

8. AGE: Years | Months | Days | If less than one day: 8 hr. 30 min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Earl Givens
13. Birthplace Va.

MOTHER
14. Maiden Name Beatrice Jett
15. Birthplace Md

16 (a) Informant Earl Givens.
(b) Address Ilchester Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-48 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md.

18 (a) Funeral director J.C. Negenbottom
(b) Address Ellicott City Md

19 DEC 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 17 1948, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1948 to 12-17 1948 and that I last saw her alive on 12-17 1948.

Immediate cause of death	Duration
Cardiac & Respiratory Failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23, Signature C.J. Schaldin

Address St. Agnes Hosp Date signed 12/17/48 M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 153

669579 BALTIMORE CITY HEALTH DEPARTMENT X V Registered No. 669579

CERTIFICATE OF DEATH 55E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Kent
(c) City or town Chestertown (If outside city or town limits, write RURAL and give town)
(d) Street No. Front St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country —

3 (a) FULL NAME Jennie Carter
3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Norman Carter
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) July 29 1902

8. AGE: Years	Months	Days	If less than one day
46	4	20	19 hr. min.

9. Birthplace Rock Hall, Kent Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John Markhart
13. Birthplace Queen Anne Co. Md.

MOTHER
14. Maiden Name Jennie Lowe
15. Birthplace Talbot Co. Md.

16 (a) Informant Mr. Norman Carter (Husband)
(b) Address Chestertown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-48 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Chester
Location Chestertown, Maryland

18 (a) Funeral director Mayers V. Williams
(b) Address Chestertown, Maryland

19 (c) DEC 19 1948 (Date received by Registrar) Chestertown Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1948 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1948 to Dec 17 1948 and that I last saw her alive on Dec 17 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Anoxia ?	
Due to Metastatic Ca	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. A. Peterson M. D.
Address University Hosp Date signed 12/18

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G69580 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 143 S. CATHERINE ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 143 S. CATHERINE ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ALBERTHA ROSALEE CASSATT ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife JOHN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 16 1880

8. AGE: Years	Months	Days	If less than one day
68	2	2	hr. min.

9. Birthplace HARRISBURG PA. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER

12. Name THOMAS KIRKPATRICK

13. Birthplace HARRISBURG PA.

MOTHER

14. Maiden Name MINNIE CARRICKNER

15. Birthplace HARRISBURG PA.

16 (a) Informant MRS. MIRIAM STOCKUM

(b) Address 143 S. CATHERINE ST.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 12/20/48 (month) (day) (year)

(c) Cemetery or crematory EAST HARRISBURG

Location HARRISBURG PA.

18 (a) Funeral director Wm. Cook Inc.

(b) Address 1217 St Paul St.

19 (a) DEC 19 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1948, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1948 to Dec 18 1948. and that I last saw him alive on Dec 17 1948.

	Duration
Immediate cause of death pneumonia	
Due to Senility	over
Due to	
Other Conditions Bronchial Asthma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Conrad London M. D.

Address 2201 W. North Ave Date signed 12-18-48

VS 150

X

G69581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 132 days
(e) Length of stay in Baltimore (yrs., mos., or days): 132 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: NY (b) County: Bronx
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: 536 E. 145th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: FRANK LAURENCE BECKER

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 097-09-6106

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 17, 1903

8. AGE: Years	Months	Days	If less than one day
45	-	-	hr. min.

9. Birthplace: New York, NY (Town, county, and state)
10. Usual Occupation: Ordinary Seaman
11. Industry or business: Seafarer

FATHER
12. Name: Frank Becker
13. Birthplace: NY, NY

MOTHER
14. Maiden Name: Louise Becker
15. Birthplace: NY, NY

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/18/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Johns
Location N.Y. City N.Y.

18 (a) Funeral director: Wm Cook Dye
(b) Address: 127 St. Paul St

19 (a) DEC 19 1948 (Date rec'd by registrar) (b) Washington Nathaniel, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 17 1948, at 11:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7 1948, to Dec. 17 1948, and that I last saw h im alive on Dec. 17 1948.

Immediate cause of death	Duration
Adenocarcinoma of Lung	6 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Robert A. English M.D.
Address: USMarine Hosp Date signed: 12-17-48

VS 150

G69582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G69582
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2201 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN H. HUGHES, Jr/

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-18-3545A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Elenora M.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 18, 1868

8. AGE: Years	Months	Days	If less than one day
80	7	29	hr. min.

9. Birthplace: Harford Co., Md.
(Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: John H. Hughes, Sr.
13. Birthplace: England

MOTHER
14. Maiden Name: Sarah A. Smith
15. Birthplace: Maryland

16 (a) Informant: Elenora M. Hughes
(b) Address: 2201 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 (a) DEC 19 1948 (Date received by registrar) (b) Registrar's signature: Wilma [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17, 1948, 19, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1948 to Dec 17 1948, and that I last saw him alive on Dec 15 1948.

Immediate cause of death: Chronic myocarditis — acute myocarditis influenza — Duration: 5 yrs.
Due to: Arteriosclerosis
Due to:
Other Conditions: Rheumatic arthritis — Terminal uremia poisoning
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: H. U. Harbold, M. D.
Address: 4706 Harford Road Completed: 12/19/48

VS 150

G69583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G69583 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 Oakford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah Sirulnik

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1892

8. AGE: Years 56 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Fruma
15. Birthplace Russia

16 (a) Informant Joseph Sirulnik
(b) Address 3023 Oakford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-48 (month) (day) (year)
(c) Cemetery or crematory Location Nerew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eastow Place

19 DEC 19 1948 (b) Washington Witherspoon, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1948, at 3 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1948 to 12/18 1948, and that I last saw her alive on 12/18 1948.

Immediate cause of death Heart failure — Duration

Due to Edhaustion, Terminal

Due to Pneumonia
Generalized
Carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation July 17, 1948
Major findings of operation: Carcinoma of Sigmoid
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benson Selwarg, M. D.
Address Sinai Hospital Date signed 12/18/4

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G69584 ✓ G69584 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Franklin Square 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2733 Penna Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isadore Greenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Regina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 78 | Months | Days | If less than one day c hr. min.

9. Birthplace Romania (Town, county and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Romania

MOTHER
14. Maiden Name Not Known
15. Birthplace Romania

16 (a) Informant Regina Greenberg
(b) Address 2733 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-48 (month) (day) (year)
(c) Cemetery or crematory Loudale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Levine Inc
(b) Address 2400 Eutaw Place

19 DEC 19 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Dec. 1948 at 11:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerd M.D. Medical Examiner.
Date signed 18 Dec. 48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69585

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G69585 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 Quantico Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Kessler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Dora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day hr.	min.
55				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation manager
11. Industry or business

FATHER
12. Name David
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Dora Kessler
(b) Address 2536 Quantico Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 400 Eastern Place

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/48 19 . at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1948 to 12/18 1948.
and that I last saw him alive on 12/18 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension & Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Sinai Hospital
Address Date signed 12/19/48 M D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69586

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G69586

1. PLACE OF DEATH: West Baltimore General
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Hanlon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Salit

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Esther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 25, 1889

8. AGE: Years	Months	Days	If less than one day
58	11	24	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Jacob Salit
13. Birthplace Russia

MOTHER
14. Maiden Name Eva ?
15. Birthplace Russia

16 (a) Informant Mrs Mildred Baron
(b) Address 3015 Hanlon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) DEC 19 1948 (Date rec'd by registrar) (b) Livingston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Dec 1948 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Dec 1948 to 18 Dec 1948, and that I last saw h[illegible] alive on 18 Dec 1948

Immediate cause of death Coronary Myocardial infarction — Duration

Due to Coronary Thrombosis

Due to Arteriosclerosis

Other Conditions Pulmonary tuberculosis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. P. Young M.D.
Address West Baltimore General Hosp. Date signed 12-20-48

VS 150

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

G69587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH *937

Registered No. G69587

The entries on this certificate, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3222 Milford Ave. Balt. 7
(c) Hospital or institution: 28-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74-3-16

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 7 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3222 Milford Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ELIZIBETH RIDGAWAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Mr. James Ridgaway
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) August 24 1874

8. AGE: Years	Months	Days	If less than one day
74	3	14	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Charles E. Steinwedel
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Heiner
15. Birthplace Maryland

16 (a) Informant Mr. James Ridgaway
(b) Address 3222 Milford Ave. Balt. 7 Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/18/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON-PARK
Location Baltimore Md

18 (a) Funeral director F. D. WIPPERT. Son
(b) Address 300 Eutaw Place

DEC 19 1948 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1948, at 5 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1948, to Dec. 16 1948 and that I last saw her alive on Dec. 15, 1948.

Immediate cause of death Respiratory Failure — Duration: 72 hours
Due to Congestive Heart Failure — 10 years
Due to Arteriosclerotic Cardio Vascular Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None made

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Millard J. Trabord Jr. M. D.
Address 3400 Woodbine Ave, Balt. 7 Date signed 12/16/48

VS 150

G69588

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 122B

G69588 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 N. Port Street,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
216 N. Port Street
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Foy

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 / 29 / 60

8. AGE: Years	Months	Days	If less than one day
88	3	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business domestic

FATHER
12. Name John Dobernick
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Mrs. List
(b) Address 2844 Harlem Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly & Zeiler, Inc
(b) Address 403 S. Wolfe Street

19 (a) 12 9 1948 (Date received by registrar) (b) Irvin Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/1948, at 5. A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13-48 1948 to 12/17/48 1948 and that I last saw her alive on 12/16/48 1948

Immediate cause of death	Duration
Intestinal obstruction	36 hours
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Faulkner M. D.
Address 100 N. Milton Ave Date signed 12/19/48

X

Type or write clearly with pen and INK. DO NOT USE PENCIL, WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669:589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

669:589

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 Buchfield Ave.
(c) Hospital or institution: 281

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Buchfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn B Burgw

3 (b) If veteran, name war

3 (c) Social Security Account No. 148-14-3593

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Wm B Burgw
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) March 7 1904

8. AGE: Years	Months	Days	If less than one day
44	9	10	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Stenographer
11. Industry or business

FATHER
12. Name John Carter
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Meredith
15. Birthplace Phila Pa

16 (a) Informant Wm B Burgw
(b) Address 3 Buchfield Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave Balto Md

18 (a) Funeral director J F Elvin Sons
(b) Address Reisterstown Md.

19 DEC 20 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Dec 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Dec 1948 to 17 Dec 1948, and that I last saw her alive on 17 Dec 1948.

Immediate cause of death: Carcinoma head of Pancreas with Metastasis — Duration: 6 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 27 Nov 48
Major findings of operation: See above
Microscopic examination: Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H Craig MD M. D.
Address 4508 Edmondson Ave Date signed 19 Dec 48

VS 3

669590

3805 Belair Rd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

669590 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 E. BIDDLE ST.
(c) Hospital or institution:
10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 E BIDDLE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE M. MILES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W

6 (b) Name of husband or wife EUGENE S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18-1867

8. AGE: Years	Months	Days	If less than one day
81	1	28	hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace - - -

MOTHER
14. Maiden Name - - -
15. Birthplace - - -

16 (a) Informant GEORGE MILES
(b) Address 414 E BIDDLE ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location OLD FREDERICK Rd

18 (a) Funeral director Blayney F. Hoffman
(b) Address 1639 Broadway

19 DEC 20 1948 (Date rec'd by registrar) Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1948, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to 12/16 1948 and that I last saw her alive on 12/15 1948

Immediate cause of death: Coronary occlusion — Duration: 2 days

Due to: Ch. myocarditis
Arteriosclerosis

Due to: Hypertension Ch.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. Harding M. D.
Address 3805 Belair Rd Date signed 12/17/48.

VS 199

X

69591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G69591 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Address
(c) Hospital or institution: Franklin Square Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Penrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry George Ebenbach

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife May E
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mch 19 1880

8. AGE: Years	Months	Days	If less than one day
68	9	29	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired Patrol
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant Mrs Carrie E. Koerber
(b) Address 216 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Guy C. Farley
(b) Address Fulton & Fayette

19 (a) DEC 20 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1948, at 9 05 A. M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kelbert M.D. Medical Examiner
Date signed 12/18/48

VS 131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69592

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Kossuth Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MALVIN J. KNIGHT

3 (b) If veteran, name war: S. A.

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1882

8. AGE: Years 66 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Samuel Knight
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mry Gamber
15. Birthplace: Md.

16 (a) Informant: Leo Knight
(b) Address: 125 S. Kossuth 12/24/48

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-48 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: GEORGE A. FARLEY
(b) Address: Fulton Ave. & Fayette St.

19 DEC 20 1948 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1948, at 11:40 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rogl M.D.
Medical Examiner
Date signed 12-17-48

VS 181

X

G69593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G69593

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Thirty Third Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Roland Pk Apts, Balto 10 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mr. William W. Edmondson Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-14-1870

8. AGE: Years 78 | Months 6 | Days 28 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation retired

11. Industry or business —

FATHER 12. Name Wm. W. Edmonson
13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret L Cooper
15. Birthplace Baltimore

16 (a) Informant Mrs. J. Hogan Edmondson
(b) Address Roland Pk. Apts, Balto 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20 48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 102 W. North Ave, City 17

19 DEC 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18 1948, at 7° A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1948, to 12-18 1948, and that I last saw h[illegible] alive on 12-17 1948.

Immediate cause of death: Cardiorespiratory failure — Duration 38 hrs
Due to intestinal obstruction — 3 months
Due to carcinoma of rectum — 3 years
Other Conditions arteriosclerosis generalized — 10 yrs
(If female pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: 12-18-48 By above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Rawcliffe Jr. M.D.
Address Union Memorial Hosp. Date signed 12-20-48

VS 150

X

G69594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69594

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave
(c) Hospital or institution: Wilson's Rest Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Owings Mills (If outside city or town limits, write RURAL and give town)
(d) Street No. (none) (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Etta May Wedge

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thos. V. Wedge

6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr) May 15 1877

8. AGE: Years 71 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Denton Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Jos. T. Stem
13. Birthplace Md.

MOTHER
14. Maiden Name Charlotte Stem
15. Birthplace Md

16 (a) Informant Ella L. Wedge - (daughter)
(b) Address St Paul Apt - Oct 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (R. F. HOOKER SUC.) 100 N. HOWER AVENUE

19 DEC 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1948, at 2:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946, to Dec 18 1948, and that I last saw her alive on Dec 18 1948.

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Cerebral Vascular Accident	2 yrs
Due to Hypertension	18 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H. Royce M.D.
M. D.
Address Pikesville 8 - Md Date signed 12-18-48

VS 150

G69595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G69595

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4318 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: MAGGIE ELIZABETH THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Geo.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1878

8. AGE: Years	Months	Days	If less than one day
70	4	28	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Own home

FATHER
12. Name John T. Edmondson
13. Birthplace Md.

MOTHER
14. Maiden Name Parrish
15. Birthplace Md.

16 (a) Informant Mr. James A. Thomas
(b) Address Sykesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21-48 (month) (day) (year)
(c) Cemetery or crematory Springfield
Location Sykesville, Md.

18 (a) Funeral director HARRY WEBER
(b) Address Sykesville, Md.

19 (a) DEC 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 19 48 at 8:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured vertebrae.
Fractured pelvis.
Fractured ribs.
Fractured tibia and fibula.
Lacerations of liver and lungs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 27/15
(a) Date of injury 12-17-48 at 5:30 P. M.
(b) Where did injury occur? 20' S. of Falls Rd. & Roland Hgts. Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/18/48

VS 151

X

69596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 69596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 Cadley Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-3

(e) Length of stay in Baltimore (yrs., mos., or days) 44 y.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 Cadley Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Helen Michaels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife George F. Michaels
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 11-29-1893

8. AGE: Years	Months	Days	If less than one day
55	0	18	hr. min.

9. Birthplace Brooklyn Anne Arundel (Town, county, and state)
10. Usual Occupation housewife Aunty.
11. Industry or business

FATHER
12. Name George Brown
13. Birthplace not known

MOTHER
14. Maiden Name Carrie Slice
15. Birthplace not known

16 (a) Informant George F. Michaels
(b) Address 2315 Cadley Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Rd. Md.

18 (a) Funeral director Bayard F. Pilgrim Jr.
(b) Address 6009 Harford Road

19 DEC 20 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17 1948 at 12 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1948 to 12-17 1948 and that I last saw h[illegible] alive on 12-15-1948.

Immediate cause of death Acute heart failure — Duration 4 days
Due to Coronary sclerosis
Due to generalized arteriosclerosis
Other Conditions Diabetes
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter H. Longnecker M.D.
Address 2708 Hollins Ferry Rd. Date signed 12/17/48

V S 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 669597

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5915 Highgate Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-20
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Ringtown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara M. Reichelderfer

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Chas. A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22 - 1883

8. AGE: Years 65 | Months 0 | Days 24 27 | If less than one day hr. min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Geo. Brobst
13. Birthplace Penna.

MOTHER 14. Maiden Name Hilda Stanley
15. Birthplace Penna

16 (a) Informant Chas A. Reichelderfer
(b) Address 5915 Highgate Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/48 (month) (day) (year)

(c) Cemetery or crematory
Location Ringtown Penna

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans St.

19 DEC 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1948, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to 1948.
and that I last saw he alive on 12/16 1948.

Immediate cause of death Coronary occlusion

Due to Hypertensive arterio-sclerotic Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dennis Mitchell M.D.
Address 572 Pine Street Date signed 12/20/48

VS 150

G69598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Hrs 40 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 W. Mulberry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JOHN LYNCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 53 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 8 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 20 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 2:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11/19/48

X

669599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

ES- 124239

13B

Registered No. 669599

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Patapasco Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Block

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1891

8. AGE: Years	Months	Days	If less than one day
57	9	29	hr. min.

9. Birthplace Penn. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Block
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta ?
15. Birthplace Germany

16 (a) Informant RECORDS* BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location University Medical School DEC 10 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 20 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

A

20. DATE OF DEATH 11-21 1948, at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2- 1948 to 11-21 1948, and that I last saw him alive on 11-21 1948.

Immediate cause of death Far Advanced Pulmonary Tuberculosis — Duration 2 Yrs

Due to

Due to Malnutrition — over

Other Conditions Fractured ribs — ? ?

Fetal (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Grant M. Shipley M. D.
Address Balto. City Hosp. Date signed 12-2-48

VS 193

G69600

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G69600

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Crownsville Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 Market St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES SIMMONS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant R H Simmons (nephew)
(b) Address 29 Market St Frederick

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School

DEC 14 1948
Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) DEC 20 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1948, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1948 to 12-9 1948, and that I last saw h unlive on 12-9 1948.

Immediate cause of death Nonpneumonic circulatory collapse

Due to Typhoid fever

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Galenbeemer
Address unk. Hosp. Date signed 12.9.48

VS 150

669601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 669601

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4411 Park Heights Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: WALLACE SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant:
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 DEC 20 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1948, at 11:25 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner. M.D.
DJM
Date signed 11-30-48

DEC 8 1948 Commissioner of Health

VS 131

669602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 669602

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 So. Pulaski St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 So. Pulaski St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph J. Price

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Widowed

6 (b) Name of husband or wife Maggie A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 5th 1862

8. AGE: Years	Months	Days	If less than one day
86	4	12	hr. min.

9. Birthplace St Mary's Co. Md.
(Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Victor G. Bleda Co

MOTHER / FATHER
12. Name Thomas Price
13. Birthplace St Mary's Co. Md
14. Maiden Name Julia Goldsborough
15. Birthplace St Mary's Co. Md.

16 (a) Informant Mrs Julia A. Etterman
(b) Address 2026 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 90-03 Hollins St.

19 (a) Date received by local registrar DEC 20 1948 (b) Registrar Thurlington White

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17th 1948 at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1948 to Dec 17 1948 and that I last saw h~~im~~ alive on Dec 17 1948.

Immediate cause of death	Duration
Carcinoma Thrombosis	
Due to Hypertension	
Due to Hyperditis	
Other Conditions Cerebral Edema	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C Ritchie
Address 345 N Milton Ave Date signed 12-17-48 M. D.

VS 153

G69603

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131B

Registered No. G69603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 503 N. Fremont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGIANNA BALLANGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Spartanberg, Virginia
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Blise Ballanger
13. Birthplace South Carolina

MOTHER
14. Maiden Name Gertrude Paden
15. Birthplace South Carolina

16 (a) Informant Robert Ballanger
(b) Address 501 N. Fremont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Maryland

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Avenue

19 DEC 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1948, at 4:10A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic nephritis
Myocardial hypertrophy
Anasarca
Uremia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Geo. G. Merrill M.D.
Medical Examiner.
Date signed 12-17-48

VS 151

X

G59604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G59604

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 640 Greenwillow Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL F. MURRAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Josephine Murray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Charlotte, North Carolina
(Town, county, and state)
10. Usual Occupation Boot Black
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace North Carolina

MOTHER
14. Maiden Name Unknown
15. Birthplace North Carolina

16 (a) Informant Alberto Ervin
(b) Address 1007 2nd St., N.E., Wash.D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-48 (month) (day) (year)
(c) Cemetery or crematory
Location Charlotte, N.C.

18 (a) Funeral director WILLIAM A. JACKSON
(b) Address 916 Pennsylvania Avenue

19 DEC 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1948, at 8:25P M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 12-18-48

G69605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G69605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Dora Schnaper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1886

8. AGE: Years 62 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Hyman

13. Birthplace Russia

MOTHER 14. Maiden Name Not known

15. Birthplace Russia

16 (a) Informant Isadore Schnaper

(b) Address 2800 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc.

(b) Address 2100 Eutaw Place

19 (a) DEC 20 1948 (b) Registered by (Signature) Hunter for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 19 - 1948, at 5:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19-1948 to 12-19-1948, and that I last saw h[illegible] alive on 12-19-1948

	Duration
Immediate cause of death: Myocardial failure	
Due to: Rheumatic heart disease (Initial stenosis + insufficiency)	
Due to:	
Other Conditions: Arteriosclerosis Cholelithiasis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address Sinai Hosp. Date signed 12-20-48 M. D.

VS 150

G69606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69606

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Carroll
(c) City or town Hampstone (If outside city or town limits, write RURAL and give town)
(d) Street No. State Sanatorium (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME August Culmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bonita

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 5-23-84

8. AGE: Years: 64 | Months: 6 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Physician

11. Industry or business

MOTHER / FATHER

12. Name: Emil Culmann

13. Birthplace: Germany

14. Maiden Name: Anna Saenger

15. Birthplace: Germany

16 (a) Informant

(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-48 (month) (day) (year)

(c) Cemetery or Crematory: Rosedale

Location: Philadelphia Rd & Hamilton Ave

18 (a) Funeral director: Jack Lewis Inc

(b) Address: 4900 Eastern Place

19 (a) 12/20/48 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1948 to 12/19 1948 and that I last saw him alive on 12/19 1948

Immediate cause of death: Coronary Occlusion — Duration: Instant

Due to

Due to

Other Conditions: Huge colloid goiter — Duration: 34 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J C Handelsman M. D.

Address: Johns Hopkins Hosp Date signed 12-19-48

VS 190

Please fill in all items, if information is not known or cannot be ascertained, state so. Physicians: please write the causes of death clearly and legibly.

G69607

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G69607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 N. Broadway D.O.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Levine

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Mordecai
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Poland

MOTHER
14. Maiden Name Not Known
15. Birthplace Poland

16 (a) Informant Charles Levine
(b) Address 117 No Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1948, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CVD disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12-20-48

VS 181

G69608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

✓ Registered No. G69608

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 W. Cold Spring Lane

(c) Hospital or institution: Cold Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2202 E. Pratt St (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Feldman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	widow

6 (b) Name of husband or wife Jacob.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/30/58

8. AGE: Years	Months	Days	If less than one day
90	10	17	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Domestic

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Feldman

15. Birthplace "

16 (a) Informant Chas. F Carwarden

(b) Address 3219 Kenyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location Berea Hill Road

18 (a) Funeral director Lilly & Zerbst

(b) Address 402 S Wolfe St

19 DEC 20 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16/1948, at 6:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1948, to 12-16 1948, and that I last saw her alive on 12-15 1948.

Immediate cause of death	Duration
HYPOSTATIC PNEUMONIA	4 days
Due to ARTERIOSCLEROSIS GENERALIZED	15 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Norman R Kleiman M. D.

Address 3813 Edmondson Ave Date signed 12/20/48

VS 150

48-27188 Mrs Stern 6.13.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G69609

G65609 LCH-125161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 min.
(e) Length of stay in Baltimore (yrs., mos., or days) N.B.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY EVANS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/7/48

8. AGE: Years	Months	Days	If less than one day
N.B.			hr. 20 min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Matthew Evans
13. Birthplace N.C.

MOTHER
14. Maiden Name Eunice Foster
15. Birthplace Va.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue 9 A.M.
17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 12-9-48 (month) (day) (year)
(c) ~~Cemetery~~ or crematory B.C. Hospital
Location 4940 Eastern ave.
18 (a) Funeral director
(b) Address
19 DEC 20 1948 (Date rec'd by Registrar) (b) Curtis for Williams Mfg

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7/48 19 , at 11:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7/48 19 , to 12/7/48 19 , and that I last saw him alive on 12/7/48 19 .

Immediate cause of death Congenital Heart & Hydrocyan — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congenital Heart

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 444 Eastern ave Date signed 12/9/48

M. C. 150

DEC 20 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69610

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

Registered No. G69610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1377 N. Chappele St
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1377 N. Chappele St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irvin Bailey George Irvin Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Anna Bailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10-1898

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50	4	5		

9. Birthplace Eastern Shore Md (Town, county, and state)
10. Usual Occupation Sailor
11. Industry or business

FATHER
12. Name Henry Bailey
13. Birthplace Eastern Shore Md

MOTHER
14. Maiden Name Ella Stafford
15. Birthplace Eastern Shore Md

16 (a) Informant Anna Bailey
(b) Address 1377 N. Chappele St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Clara O. Wilson
(b) Address 1000 Brantley Rd

19 DEC 20 1948 (Date rec'd by registrar) (b) [illegible] (Registrar)

12-15-48 MEDICAL CERTIFICATION 10 30 pm

20. DATE OF DEATH Dec 15 1948, at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1948 to Dec 15 1948, and that I last saw him alive on Dec 15 1948.

Immediate cause of death	Duration
Bronchopneumonia	5 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Garland Grimsley M.D.
Address 902 W Franklin Date signed 12-14-48

VS 153

Contributor Baltimore, Md.

G69611 Dr. Peake

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83B

Registered No. G69611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4504 Mainfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4504 Mainfield Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antonia E. Smuck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Walter S. Smuck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1878

8. AGE: Years	Months	Days	If less than one day
70	4	15	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Karl G. Eigenbrodt
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha ?
15. Birthplace Germany

16 (a) Informant Mr. Walter S. Smuck
(b) Address 4504 Mainfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore

18 (a) Funeral director Leonard J. Huck
(b) Address 5305 Harford Road #14

19 (a) DEC 20 1948 (Date rec'd by registrar) (b) Huntingtown, Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17th 1948, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24- 1948 to 12-17- 1948 and that I last saw her alive on 12-17 1948

Immediate cause of death: Cerebral Thrombosis — Duration: 4 weeks
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4508 Harford Rd Date signed 12-13-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G69612

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution: Mercy Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 E. Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE R. HELDMANN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife LOUIS W. HELDMANN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 2P, 1881

8. AGE: Years	Months	Days	If less than one day
67	6	19	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business None

FATHER
12. Name Christian Kogler
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schuster
15. Birthplace Germany

16 (a) Informant: Husband
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 12/21/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director J. J. Luck
(b) Address 5305 Harford Rd.

19 (a) DEC 20 1948 (Date rec'd by registrar) **(b)** Clinton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1948, at 6 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1948, to Dec 17 1948, and that I last saw her alive on Dec 17 1948.

Immediate cause of death Heart Failure — Duration: Several Years

Due to Hypertensive cardio-vascular disease — Duration: over 9 mos. 2 yrs.

Due to

Other Conditions Generalized Cancer and Toxic
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M Buchner M.D.
M. D.

Address Mercy Date signed Dec 17, 1948

VS 150

93D

G69613

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G69613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Cathedral St
(c) Hospital or institution:

11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Cathedral St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Graf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife George Graf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 18 1878

8. AGE: Years	Months	Days	If less than one day
70	9	0	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Henry Eifert
13. Birthplace

MOTHER 14. Maiden Name Elizabeth Pfeil
15. Birthplace

16 (a) Informant Mr. Carl Eifert
(b) Address 6707 Old Harford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/48 (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd

19 (a) DEC 20 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Dec. 1948 at 1:50 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D.
Medical Examiner.
Date signed 18 Dec. 48

VS 151

Please write the causes of death clearly and legibly.

669614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 669614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(b) Street No. 5504 Hamlet Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd WALDEN

3 (b) If veteran, name war

3 (c) Social Security Account No. 324-03-3097

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Hazel Mays
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1894

8. AGE: Years	Months	Days	If less than one day
54	0	27	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation salesman

11. Industry or business

FATHER
12. Name Emlyn Walden
13. Birthplace N.Y.

MOTHER
14. Maiden Name Martha Flack
15. Birthplace Iowa

16 (a) Informant Mrs. Hazel M. Walden
(b) Address 5504 Hamlet Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-48 (month) (day) (year)
(c) Cemetery or crematory Arlington Nat'l
Location Fort Meyer, Va.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) DEC 20 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/48 19 , at 9.55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 12/18/48

VS 151

X

G69615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 114c

Registered No. G69615

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ... 16
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ...
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3029 Raynor Ave #16 (If rural give location)
(e) Citizen of foreign country? ... (Yes or No) If yes, name country ...

3 (a) FULL NAME Elizabeth Nora Durham (NORA E.)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife Edgar Allan Durham (deceased)
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Oct 11, 1865

8. AGE: Years	Months	Days	If less than one day
83	2	8	hr. ... min.

9. Birthplace Anne Arundel Co. Maryland (Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Robert Hawkins
13. Birthplace Anne Arundel Co. Maryland

MOTHER
14. Maiden Name Susanna Elder
15. Birthplace Anne Arundel Co. Maryland

16 (a) Informant George Martin — Son
(b) Address 3029 Raynor Ave. #16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21 48 (month) (day) (year)
(c) Cemetery or crematory Waugh Chapel
Location Gdenton Md

18 (a) Funeral director Harry H. Wiltsie
(b) Address 4101 Edmondson Ave

19 (a) Dec 20 1948 (Filed by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1948, at 2 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1948 to 12/19 1948, and that I last saw her alive on 12/19 1948.

Immediate cause of death	Duration
Pulmonary Hemorrhage	1 min.
Due to Pulmonary Infarct	1 day
Due to ...	...
Other Conditions Generalized Arteriosclerosis	...

(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
Pericardial Abscess; Necrosis of Lung base
Results of autopsy ...

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury ...

23. Signature Wm A Stark
Address Md Gen Hosp Date signed 12/19/48 M.D.

VS 150

111c

G69616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69616

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Use typewriter or black ink.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 E 36th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 E 36th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nicholas Moretti (NAZZARENO MORETTI
3 (b) If veteran, name war
3 (c) Social Security Account No. 219-22-0005

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife GIORANNA
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1878
8. AGE: Years 70 | Months | Days | If less than one day hr. min.
9. Birthplace ITALY (Town, county, and state)
10. Usual Occupation TAILOR
11. Industry or business

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 20-48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location 4500 Edmondson Ave
18 (a) Funeral director Harry A Nuthe
(b) Address 4141 Edmondson Ave
19 DEC 20 1948 (Date received by registrar) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1948 at 8:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1948 to Dec. 16 1948 and that I last saw him alive on Dec. 16 1948.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerotic Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilson H. Fusting, M.D.
Address 11 E. Chase St. Date signed 12-16-48

VS 150

G69617 ✓ G69617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1 2
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** William Spencer Harrison Harris

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mabel Harris

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 4 1893

8. AGE: Years 55 | Months 5 | Days 12 | If less than one day: ..... hr. ..... min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business .....

FATHER
12. Name William Harris
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Matilda ?
15. Birthplace Howard Co. Md.

16 (a) Informant Mollie Mackall
(b) Address 129 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location .....

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 20 1948 (Date rec'd by registrar) Registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1948, at 2 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Dec 16 1948.
and that I last saw h alive on ..... 19 .

Immediate cause of death Coronary Thrombosis
Due to Myocardial degeneration and Hypertension

Duration 1½ Mos. nursing care

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature John L. Stewart M. D.
Address 6 S. E. Franklintown Date signed Dec 20 48

VS 153

G69618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G69618 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 S. Patterson Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD F. EAGAN Jr.

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha M.
6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) April 10 1923

8. AGE: Years	Months	Days	If less than one day
25	8	8 7	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Gas Station Attendant
11. Industry or business

FATHER
12. Name Edward Eagan
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Theresa Mitchell
15. Birthplace Baltimore, Maryland

16 (a) Informant Bertha M. Eagan
(b) Address 412 S. Patterson Park Avenue

17 (a) Burial (b) Date thereof 12-21-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director DIPPEL BROTHERS
(b) Address 1800 E. Lombard Street

DEC 20 1948 (b) Washington Veterans
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1948, at 11:30PM

21. I certify that I took charge of the remains described above, held an Aut psy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-17-48 at 11:00 P. M.
(b) Where did injury occur? 1929 E. Pratt Street
(c) Did injury occur at home, on farm, industrial place, in public place? a home While at work? no
(d) Means of injury Firearms

23. Signature Carl L Boyer M.D.
Medical Examiner
Date signed 12-18-48

VS 181

G69619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 B

G69619
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 8.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2415 E. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lillie C. Baker

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-22-0293

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife James C.
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr) July 18 1895

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	5	2		

9. Birthplace Bishops. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Samuel J. Collins
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Derrickson
15. Birthplace Del.

16 (a) Informant James C. Baker Sr.
(b) Address 2415 E. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 23 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Dugan Bros
(b) Address 1800 E. Lombard St.

19 (a) 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1948 at 7 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1948 to Dec 20 1948 and that I last saw h(er) alive on Dec 12 1948.

Immediate cause of death: Uremia — Duration:
Due to: Chronic Glomerular Nephritis
Due to: Hypertensive Vascular disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None Attended

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F Bowen M.D.
Address Univ. Hosp. Date signed 12/28/48 M. D.

VS 150

X

G69620 BALTIMORE CITY HEALTH DEPARTMENT G69620 Registered No. L4742

CERTIFICATE OF DEATH 937

The medical certification shall be completed by the attending physician, or in cases specified by law, by the coroner, within 24 hours after death. The funeral director shall file the certificate with the local registrar within 72 hours after death. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 463 Roundview Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 463 Roundview Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Marie Shipley

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	W

6 (b) Name of husband or wife Hezekiah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2. 1878

8. AGE: Years	Months	Days	If less than one day
70	10	15	hr. min.

9. Birthplace Pittsburgh Pa. (Town, county, and state)
10. Usual Occupation
11. Industry or business —

MOTHER / FATHER
12. Name Robert Doing
13. Birthplace Pittsburgh Pa.
14. Maiden Name Anna Smathers
15. Birthplace Pittsburgh Pa.

16 (a) Informant Madeline Robinson
(b) Address 463 Roundview Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-48 (month) (day) (year)
(c) Cemetery or crematory Western Star Cem
Location
18 (a) Funeral director George G. Nelson
(b) Address 803 Portsman St

19 (a) (Date received by Registrar) (b) Registrar Lexington Williams M.D.
DEC 20 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1948, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to Dec. 17 1948 and that I last saw her alive on Dec. 17 1948.

	Duration
Immediate cause of death Cerebral Hemorrhage	4 day
Due to Hypertensive-Card-Vas Disease	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R B Lightstone M. D.
Address 501 Cherry Hill Rd. Date signed 12-17-48

VS 150

G69621 ✓ G69621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No.

Physicians: please write the causes of death clearly and legibly. Punctuation is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 14
(d) Length of stay in hospital or inst. (~~years~~ days) 48
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 McCulloughs
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MELVINA PINN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Robert Pinn
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 4-29-92

8. AGE: Years	Months	Days	If less than one day
56	7	18	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Joseph Addison
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth Dawson
15 Birthplace Va

16 (a) Informant Husband
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-48 (month) (day) (year)
(c) Cemetery or crematory Warrenton Va
Location

18 (a) Funeral director George E Nelson
(b) Address 1303 Prestman St

19 (a) (Signature of local registrar) (b) Registrar

DEC 20 1948

VS 150

Contractor Williamsburg Va

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17-1948 at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29-1948 to 12-17-1948.
and that I last saw her alive on 12-12-1948.

Immediate cause of death	Duration
Cardiac failure	2 days
Due to Probable gastric ulcer	Unknown
Due to Cachexia - from ~~advanced~~ Lymphosarcoma	2½ Mos
Other Conditions Due to intra Cranial aneurysm	

(Include pregnancy within 3 months of death)

Date of operation November 1948
Major findings of operation: Angiography Intracranial dilatation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allyn F. Judd M.D.
Address Mercy Hospital Date signed 12-17-48

X

G69622 ✓ G69622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 948

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1429 E. Biddle Street
(c) Hospital or institution:

10 ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 E. Biddle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sister Mary Lucille Byrnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/18/81

8. AGE: Years	Months	Days	If less than one day
67	11	0	hr. min.

9. Birthplace Philadelphia, Penna. (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name Peter Byrnes
13. Birthplace Unknown

MOTHER
14. Maiden Name Lucy Butler
15. Birthplace Unknown

16 (a) Informant Carmelite Monastery Records
(b) Address 1429 E. Biddle Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Maryland.

18 (a) Funeral director H. H. Mears and Son
(b) Address 1805 N. Calvert St

19 DEC 20 1948 (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1948 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 . and that I last saw h alive on Dec 18 1948.

Immediate cause of death Acute Congestive Heart Failure

Due to Hypertension Angina pectoris

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation ✓

Major findings of operation: ✓

of autopsy: ✓

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis J Kirby

Address 1106 E North Ave Date signed 12 M. D. 1948

VS 150

X

G69623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69623

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Calvert + 33rd Sts.

(b) Street address ~~Esplanade Apts. Balto 17~~

(c) Hospital or institution Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22

(e) Length of stay in Baltimore (yrs., mos., or days) - 13

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore 17 (If outside city or town limits, write RURAL and give town)

(d) Street No. Esplanade Apts. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country —

3 (a) FULL NAME Mrs. Blanche R. Benesch

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband ~~or wife~~ Arthur Benesch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-18-1886

8. AGE: Years	Months	Days	If less than one day
62	11	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business —

FATHER 12. Name	Philip M. Makel
13. Birthplace	South Carolina
MOTHER 14. Maiden Name	Rosa Hurtle
15 Birthplace	Baltimore

16 (a) Informant Mr. Arthur Isaac Benesch

(b) Address Esplanade Apts.

17 (a) Burial (b) Date thereof 12/2/48.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Ohel Shalom

Location Keene. Md.

18 (a) Funeral dir. Harris Homes Inc.

(b) Address 902 Eutaw Place

19 DEC 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1948 at 6:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1948 to 12-19 1948. and that I last saw her alive on 12-19 1948

Immediate cause of death Heart failure — Duration 4 hrs

Due to Hypertensive Cardiovascular Disease — < 10 yrs

Due to —

Other Conditions Obesity

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury —

23. Signature Jeff Randolph M. D.

Address Union Memorial Hosp Date signed 12-19-48

VS 150

G69624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G69624

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3217 Fait Ave
(c) Hospital or institution: 26

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3217 Fait ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander A. David

3 (b) If veteran, name war | 3 (c) Social Security Account No. 213-03-9149

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary David
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25 1888

8. AGE: Years	Months	Days	If less than one day
60	8	21	3 hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John David
13. Birthplace Poland

MOTHER
14. Maiden Name Sophia Golaf
15. Birthplace Poland

16 (a) Informant Mrs Mary David
(b) Address 3217 Fait ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21 1948 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Baltimore, City

18 (a) Funeral director John J. Weber
(b) Address 401 S. Chester Street

19 DEC 20 1948 (Date rec'd by registrar) (b) Kenneth F. Williams, M.D. Registrar

MEDICAL CERTIFICATION

3

20. DATE OF DEATH Dec 17 1948, at AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1948 to Dec 17 1948, and that I last saw h (as) alive on Dec 14 1948.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Cardiac Decompensation	
Due to	
Other Conditions Bilateral Pulmonary Tuberculosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Za. Flanigan M.D.
Address 3503 Fait Ave Date signed 12-17-48

VS 2

95c

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69625

Medical Examiner's Office
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G69625 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street - 22
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 Light St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laurence Queen.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Cora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-2-1910

8. AGE: Years 38 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Renso
13. Birthplace N.C.

MOTHER 14. Maiden Name Georgia Walford
15. Birthplace N.C.

16 (a) Informant Family
(b) Address Same

17 (a) (Burial, cremation, or removal) (b) Date thereof 12-21-48 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location (61 B.) Brooklyn, Md.

18 (a) Funeral director Thomas J. McCarthy & Sons
(b) Address 139 E. Fort Ave. Baltimore, Md.

19 (a) DEC 20 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18-48 19 at 5.57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1948 to 12-18 1948 and that I last saw him alive on 12-18 1948.

Immediate cause of death Tetanus

Due to Lacerated wound of hand

Due to Injury to left hand

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation CERTIFICATION APPROVED BY

Major findings of operation

H. H. Merrill M. D.
CORONER OR ASST. MEDICAL EXAMINER

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 22/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12-9-48 at 11 30 A.M. or P.M.
(c) Where did injury occur? Baltimore (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Burned while welding

23. Signature Charles B. [illegible] M. D.
Address 1213 Light St. Date signed 12-19-48

VS 150

X

G69626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registered No. G69626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: MARYLAND GEN. HOSP. #25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3323 HOLLINS #25 (MASON VILLE) (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN OGONOWSKI

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	(POLISH) WHITE	MARRIED

6 (b) Name of ~~husband~~ wife ANNIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 5, 1883

8. AGE: Years	Months	Days	If less than one day
65	10	14	hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15 Birthplace

16 (a) Informant ANNIE - OGONOWSKI
(b) Address SAME AS DECEASED

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof 12-22-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Rt 40 & Edmondson Ave
18 (a) Funeral director J. McCarney & Son
(b) Address 1302 Fort Ave
19 (a) DEC 20 1948 (Date rec'd by registrar) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 DECEMBER 1948 at 6.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 NOV 1948 to 19 DEC 1948, and that I last saw HIM alive on 19 DEC 1948

	Duration
Immediate cause of death GENERALIZED PERITONITIS & MASSIVE G.I. HEMORRHAGE FROM RUPTURED RETROPERITONEAL ABCESS & BLEEDING FROM SPLENIC ABCESS INTO STOMACH	18 hours
Due to DUE TO MALIGNANT PERFORATION OF STOMACH	1 week
Due to SECONDARY TO EXTENSION OF A RETROPERITONEAL MALIGNANT LYMPHOMA	3-4 months
Other Conditions (Conditions which contributed to death but not related to immediate cause of death)	

Date of operation NONE
Major findings of operation:
of autopsy ABOVE DIAGNOSES

PHYSICIAN
*Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Donald L. England M. D.
Address MARYLAND GEN HOSP Date signed 19 Dec 48

VS 159

669627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1548

Registered No. 669627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address UNIVERSITY Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 ORLEANS ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Burke

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-7179

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	MARRIED

6 (b) Name of husband or wife ISABELLA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-30-1875

8. AGE: Years	Months	Days	If less than one day
73	5	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business

FATHER
12. Name WM. H. BURKE
13. Birthplace Md

MOTHER
14. Maiden Name LUCINDA ?
15. Birthplace Md

16 (a) Informant ISABELLA BURKE
(b) Address 1105 ORLEANS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-21-48 (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY
Location A.A. County, Md

18 (a) Funeral director Joseph B. Roche
(b) Address 1264 N. Central Ave

19 (a) DEC 20 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 19 48 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 19 48 to Dec 17 19 48, and that I last saw him alive on Dec 17 19 48

Immediate cause of death: Cardiac Failure — Duration:
Due to Arterio sclerosis
Due to
Other Conditions osteomyelitis of Mandible
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Baumbach M. D.
Address University Hospital Date signed 12/21/48

VS 150

97

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. To [illegible] information should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G69628

G69628

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital 25+5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Patapsco Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (PETER) PROKOP DOROPIEWICH (DOROP)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Julia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8 1893

8. AGE: Years	Months	Days	If less than one day
55	5	11	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Burner
11. Industry or business Md. Drydocks

FATHER
12. Name Carroll Doropiewich
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace Russia

16 (a) Informant Julia Doropiewich
(b) Address 1313 Patapsco Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/48 (month, day, year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 DEC 20 1948 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1948 at 12:22 a.m.

21. I certify that I took charge of the remains described above, held an Inspection. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Compound fractures of skull with intracranial hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 25/5
(a) Date of injury 12-18-48 at About 11:45 p. m.
(b) Where did injury occur? Patapsco Ave. at Fairhaven Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by auto.

23. Signature Emil L. Rayn M.D.
Medical Examiner.
Date signed 12-20-48

VS 151

669629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. 669629

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22[illegible] Calvert
(c) Hospital or institution:
Union memorial Hosp -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 0
(If rural give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country 0

3 (a) FULL NAME [illegible] - Mildred Guy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Uriah Guy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1898

8. AGE: Years	Months	Days	If less than one day
50	3	34	hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation At Home -

11. Industry or business

MOTHER FATHER

12. Name John [illegible] Chidley

13. Birthplace New York

14. Maiden Name Cornelia Finley

15 Birthplace New York

16 (a) Informant Uriah Carter Guy

(b) Address Providence Rd - Towson Md

17 (a) Burial (b) Date thereof 12/21/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Providence
Location Towson Md

(a) Funeral [illegible]

(b) [illegible] Ellsworth Armacost

19 (a) [illegible] 3911 Sibley Hospital

(b) [illegible] Huntington Hillcrest, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1948 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17- 1948 to 12-19 1948, and that I last saw her alive on 12-18 1948.

Immediate cause of death
Cholemia

Due to Laennec's Cirrhosis
LAENNEC'S

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy:

Duration
8 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P. Smith, Jr M. D.
Address Union Memorial Hospital Baltimore 18, Md. Date signed 12/19/48

669630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. 669630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South
(c) Hospital or institution: South Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 N. Linwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Plumhoff, Henry J.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Catherine V. Plumhoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 29-1906

8. AGE: Years	Months	Days	If less than one day
42	2	21	hr. 20 min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Policeman
11. Industry or business Balto. City

FATHER
12. Name John Plumhoff
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Bugle
15. Birthplace Balto. Md.

16 (a) Informant Catherine V. Plumhoff
(b) Address 529 N. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Gdns. Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 DEC 20 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19-1948 at 1:36 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13-1948 to 12-19-1948 and that I last saw him alive on 12-19-1948.

Immediate cause of death Uremia — Duration

Due to Chronic glomerulonephritis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature William J. Hamm, M. D.
Address 50. Baltimore Med. Bldg. Date signed 12-19-48
Balto. 30, Md.

VS 150

Physicians: please write the causes of death clearly and legibly.

G69631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G69631

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PERCY HOWARD

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Emma Howard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1884

8. AGE: Years	Months	Days	If less than one day
64	1	8	hr. min.

9. Birthplace Prince George Co., Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER	12. Name	Jim Howard
	13. Birthplace	Prince George Co., Md.
MOTHER	14. Maiden Name	Frances ?
	15. Birthplace	Prince George Co., Md.

16 (a) Informant Madie Wood
(b) Address 1224 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22, 19 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winder, Md.

18 (a) Funeral director Charles H. Alexander
(b) Address 1200 McCulloh St. Baltimore, Md.

19 (a) DEC 20 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1948, at 10:30 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 12/21/48

VS 181

G69632

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 B

Registered No. G69632

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 Kennedy Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Gertrude Martha J. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-22-2492

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clayland Williams
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 8/26/1900

8. AGE: Years 48 | Months 3 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business Radio Station

FATHER
12. Name George J. Boane
13. Birthplace Md

MOTHER
14. Maiden Name Cassandra M. Miller
15. Birthplace Carroll Co Md

16 (a) Informant Clayland A. Williams
(b) Address 2821 Kennedy Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22-48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Balto Md

18 (a) Funeral director Pratt & B. M. Walker
(b) Address Pratt & Eutaw Sts

19 DEC 20 1948 (b) Registered by Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1948 at 11:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1948 to Dec 19 1948 and that I last saw her alive on Dec 19 1948

Immediate cause of death	Duration
Acute Coronary Occlusion	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions Mitral Stenosis and Mitral Insufficiency (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Guy C. Stevens Jr. M.D.
Address 1 E Lexington St Date signed 12/19/48

VS 150

G69633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

✓ G69633 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland St.
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
17
(d) Street No. 3409 W. Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Sciarretta

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7 1887

8. AGE: Years	Months	Days	If less than one day
61	8	11	hr. min.

9. Birthplace Larino Campobasso Italy
(Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business

FATHER
12. Name GELASIO Giorgio Sciarretta
13. Birthplace Italy

MOTHER
14. Maiden Name ANASTASIA-DECHIONERO
15. Birthplace Italy

16 (a) Informant Dante Sciarretta (Son)
(b) Address 3435 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21/48 (month) (day) (year)
(c) Cemetery ~~xxxxxxxxx~~ Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 322 S. High St.

19 (a) DEC 20 1948 (Date rec'd by registrar) (b) Funeral for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1948, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1948, to Dec 18 1948, and that I last saw him alive on Dec 18 1948.

Immediate cause of death	Duration
Myocardial Infarction, Auricular Fibrillation	
Due to Hyperthyroidism & Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Baker M. D.
Address Sinai Hospital Date signed 12/18/48

VS 150

X

G69634

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G69634

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 to 40th Street
(c) Hospital or institution:
Home for Incurables 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4-15
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Beaumont Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Addie E. Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~
F	W	

6 (b) Name of husband or wife William T Ford
6 (c) If alive, give age d years

7. Birth date of deceased (mo., day, yr) Aug 9, 1872

8. AGE: Years	Months	Days	If less than one day
76	4	9	hr. min.

9. Birthplace Oriole Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Silas E. Bedsworth
13. Birthplace Md.

MOTHER
14. Maiden Name Sallie E. McDaniels
15. Birthplace Md

16 (a) Informant Mrs Frances M Hazard Supervisor
(b) Address 700 W-40th St Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md

19 (Date rec'd by Registrar) DEC 20 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1948, at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3rd 1947, to December 18th 1948, and that I last saw her alive on December 18 1948.

Immediate cause of death	Duration
Acute Myocardial Insufficiency	Suddenly
Due to Arteriosclerotic Cardiovascular Disease	Undetermined
Due to	
Other Conditions Ch. Bronchitis Emphysema Arthritis Deformans Multiple Joints (Include pregnancy within 3 months of death)	Several years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolf
Address 11 E. Chase St. Baltimore 2 Maryland
Date signed 12/18/48 (M. D.)

VS 150

G69635

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95B

Registered No. G69635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County
(c) City or town Lancaster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 42 South Prince St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MILDRED M. VOZEL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Dr. Luther F. Vozel
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1903

8. AGE: Years	Months	Days	If less than one day
45	3	27	— hr. — min.

9. Birthplace Pennsylvania (town, county, and state)
10. Usual Occupation Loans wife
11. Industry or business

FATHER
12. Name Dr. Wesley V Miller
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Augusta Shaffer
15. Birthplace Pennsylvania

16 (a) Informant Barbara L
(b) Address 42 South Prince St, Lancaster Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 20 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18 19 48 at 11 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 19 48 to 12-18 19 48 and that I last saw her alive on 12-18 19 48.

Immediate cause of death	Duration
Heart Failure	3 hrs
Due to Chronic rheumatic heart disease	
Due to	
Other Conditions Auricular fibrillation	8 yrs

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Union Memorial Hosp Date signed 12-18-48

VS 150

G69636

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

467

Registered No. G69636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Clifton Ave
(c) Hospital or institution: 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Welsh

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles Roland Welsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July

8. AGE: Years	Months	Days	If less than one day
? Abt.75			hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Betty Varstad
(b) Address 2012 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) DEC 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1948 at 2:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1948 to Dec 18 1948, and that I last saw h[illegible] alive on Dec. 11 1948.

Immediate cause of death	Duration
carcinoma of the rectum	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. A. Fetterman M. D.
Address 2314 Reisterstown Rd. Date signed 12/19/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The [illegible] information should be carefully supplied.

59637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 99

✓ Registered No. 6696637

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1608 Ellamont St.
(c) Hospital or institution:
How
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Ellamont St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CORNELIA A. MEYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Wiard A. Meyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 18, 1867

8. AGE: Years	Months	Days	If less than one day
81	9	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George McK. Barthlow
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline
15. Birthplace Md.

16 (a) Informant Mr. Wiard A. Meyer
(b) Address 1608 Ellamont St.

17 (a) Burial (b) Date thereof 12/21/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) DEC 20 1948 (b)
(Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1948, at 8:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5 July 1946 to 18 Dec 1948 and that I last saw her alive on 18 Dec 1948.

Immediate cause of death	Duration
Mesenteric Embolism	30 hrs
Due to Arteriosclerosis	indef.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 2020 N. Charles St Date signed 20 Dec 48

VS 150

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HZH 4E

G69638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G69638

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga (b) County
(c) City or town Clifton Heights (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Willowbrook Rd (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph R. McKeefery

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-5-48

8. AGE: Years	Months	Days	If less than one day
	7	14	hr. min.

9. Birthplace Ga (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph A. McKeefery
13. Birthplace Ga

MOTHER
14. Maiden Name Rita T. Galanaugh
15. Birthplace Ga

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Philadelphia

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 S. Wolfe St

DEC 20 1948 (Date rec'd by registrar)
(b) Registrar
Lenington for Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19-1948, at 7:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16-1948 to 12-19-1948, and that I last saw him alive on 12-19-1948.

Immediate cause of death: Cardiac failure — Duration

Due to: Congenital heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-18-48

Major findings of operation: Dextrocardia with transposition

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature a. c. Fang M. D.
Address Johns Hopkins Hosp. Date signed 12-20-48

X

G69639 — ES-125376

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

16 — G69639 Registered No.

Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVENUE
(c) Hospital or institution: BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 East Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Viola Brockett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1905

8. AGE: Years	Months	Days	If less than one day
43	8	15	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Sylvester Conigland
13. Birthplace N.C.

MOTHER — 14. Maiden Name Roxie Jones
15. Birthplace N.C.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVENUE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-48 (month) (day) (year)

(c) Cemetery or crematory
Location North Carolina

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bromley Rd

19 (a) (b) (Date rec'd by registrar) Lexington Williams, M.D.

DEC 20 1948

MEDICAL CERTIFICATION

P

20. DATE OF DEATH 12-18 1948, at 6:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1948 to 12-18- 1948, and that I last saw her alive on 12-18 1948.

Immediate cause of death: Tuberculous meningitis — Duration: days

Due to: Lobar pneumonia, Acute — ?

Due to: Healed Tuberculosis

Other Conditions: Lungs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature

Address Balto City Hosp. Date signed 12/19/48 M. D.

V S 150

G69640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 669640

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4027 CRANSTON AVE..
(c) Hospital or institution: ********** **
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 4027 CRANSTON AVE. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LORETTA M. LARICOS

3 (b) If veteran, name war ********
3 (c) Social Security Account No. *********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife William G. Laricos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 24, 1911

8. AGE: Years	Months	Days	If less than one day
37	5	24	hr. min.

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business AT HOME

FATHER
12. Name ROMAN C. NITSCH
13. Birthplace MARYLAND

MOTHER
14. Maiden Name LORETTA S. MOORE
15. Birthplace MARYLAND

16 (a) Informant WILLIAM G. LARICOS
(b) Address 4027 CRANSTON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 21/48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDERAL
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE...17

19 (a) DEC 20 1948 (Date rec'd by registrar) (b) Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 18/ 1948, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March/ 1948, to Dec 18 1948, and that I last saw her alive on 1948.

Immediate cause of death Dec 18- Cerebral Hemorrhage Brain Cardiac Arrest
Due to
Due to
Other Conditions Metastasis to Spine
(include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C Nitsch M. D.
Address Wilkens Ave. Date signed 12/

VS 150

G69641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G69641 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — PROTH. D.of
(b) Street address 2211 W Pratt St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN E. LANE - John E Lane

3 (b) If veteran, name war: W.W. I

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARIE M. LANE

6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): MARCH 6th. 1894

8. AGE: Years 54 | Months 9 | Days 11 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MARYLAND (Town, county, and state)

10. Usual Occupation: MANAGER

11. Industry or business: WILSON TRANSFER

FATHER
12. Name: WILLIAM C. LANE
13. Birthplace: MARYLAND

MOTHER
14. Maiden Name: KATHERINE STAIB
15. Birthplace: MARYLAND

16 (a) Informant: MARIE M. LANE (WIFE)
(b) Address: 2211 W. PRATT STREET

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC.20/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 EUTAW PLACE.17

19 (a) (b)
Dec 20 1948
Registered by registrar — Covington Williams, M.D.

VS-131

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1948 at 6 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to d. r. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12/17/48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G699642

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. 19 Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 E. St. Spanone Point
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Hobbs Turpin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed~~, or ~~divorced~~
m	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 8, 1888

8. AGE: Years	Months	Days	If less than one day
60	3	11	hr. min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation Machine Cut Off Operator

11. Industry or business Bethl. Steel Co.

FATHER
12. Name Peter Turpin
13. Birthplace Virginia

MOTHER
14. Maiden Name Jones
15. Birthplace Virginia

16 (a) Informant Arola Funeral Home
(b) Address Buena Vista, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22, 1948 (month) (day) (year)

(c) Cemetery or crematory
Location Buena Vista, Virginia

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

DEC 21 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1948, to 12/19 1948, and that I last saw h Im alive on 12/19 1948.

Immediate cause of death Cardiac failure — Duration

Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions Decompensation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify t.p., f. place)
(e) Means of injury

23. Signature William S. Womack M. D.
Address Bon Secours Hosp Date signed 12/19/48

VS 150

G69643 B.C. 48-22606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G69643 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald E. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/11/48

8. AGE: Years	Months	Days	If less than one day
	2	8	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Ira Miller
13. Birthplace Pa.

MOTHER
14. Maiden Name Doris Kuss
15. Birthplace Pa

16 (a) Informant Mother
(b) Address 1213 W. Baltimore St.

17 (a) Burial (b) Date thereof 12/22/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 21 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1948, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1948 to 12/19 1948, and that I last saw h/m alive on 12/19 1948.

Immediate cause of death Atelectasis or Pneumonitis

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mathes M. D.

Address Univ. Hosp. Date signed 12/20/48

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Physicians: please write the causes of death clearly and legibly. Be sure to answer every question. Use no abbreviations. Omit no important information.

669644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

AB-125274

Registered No. G669644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 9yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Viola Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13-1907

8. AGE: Years	Months	Days	If less than one day
41	11	5	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Johnson
13. Birthplace Seaford Delaware

MOTHER
14. Maiden Name Harriett Bowden
15. Birthplace Concord Delaware

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Wolliam Cook Inc.
(b) Address 127 St. Paul St.

19 DEC 21 1948 (Date rec'd by Registrar) (b) Huntington Wills Registrar, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18- 1948, at 11.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11- 1948, to 12-18- 1948, and that I last saw h er alive on 12-18- 1948

Immediate cause of death TUBERCULOSIS OF LUNGS AND MULTIPLE LYMPH NODES — Duration: ?
Due to
Due to
Other Conditions ASCITES
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: NONE
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas P. Jennings M. D.
Address BALTIMORE CITY HOSP Date signed 12-18-48

V S 150

Please answer all questions. Physicians: please write the causes of death clearly and legibly.

669645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

ES-74372 47a

Registered No. 669645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVENUE
(c) Hospital or institution: BALTO. CITY HOSPITALS 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town) 12
(d) Street No. No address (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Rutherford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 18, 1868

8. AGE: Years	Months	Days	If less than one day
80	4	0	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew Rutherford (D)
13. Birthplace Scotland

MOTHER
14. Maiden Name Brigid King (D)
15. Birthplace Ireland

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVENUE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) DEC 21 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18 1948, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1942, to 12-18 1948, and that I last saw him alive on 12-18-48 1948.

Immediate cause of death Bilateral Bronchopneumonia — Duration 2 days
Due to
Due to
Other Conditions Carcinoma of Larynx with metastasis to R. Lung
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: to above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Wm. Kay M.D.
Address Balto. City Hospital Date signed 12/20/1948

V S 190

107

659646

47895-5

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47

659646
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 134 N Exeter, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Leon

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1876

8. AGE: Years	Months	Days	If less than one day
72 ?			hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Peanut Seller
11. Industry or business

FATHER
12. Name James Leon
13. Birthplace Greece

MOTHER
14. Maiden Name Enoch ?
15. Birthplace Greece

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 12/22/48 (month) (day) (year)
(c) Cemetery or crematory Greek Community
Location Druid Lawn Md

18 (a) Funeral director Williams & Son Inc
(b) Address 1219 W Lone St

DEC 21 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1948 at 6 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24- 1948 to 12- 18- 1948, and that I last saw him alive on 12-18- 1948.

Immediate cause of death	Duration
Respiratory obstruction	
Due to Oat cell carcinoma	
Due to of lung	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D Wisbeuch
Address JOHNS HOPKINS HOSPITAL Date signed 12 M 18 D 48

VS 150

DEC 18 1948

G69647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G69647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 S. Stricker Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 340 S. Stricker Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE JOYCE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John T. Joyce
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 14, 1888

8. AGE: Years	Months	Days	If less than one day
60	2	3	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William H. Wiebking
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Lutz
15. Birthplace Baltimore

16 (a) Informant Mrs. Anna Linker
(b) Address 340 S. Stricker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Dec 21 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 17th 1948, at 6 4. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1948 to Dec 17 1948, and that I last saw h[illegible] alive on Dec 17 1948.

Immediate cause of death Coronary Embolism — Duration

Due to Coronary Thrombosis

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James T. Talbot M. D.
Address 921 Medical Arts Date signed 12-21-48

VS 150

669648

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

669648
Registered No.

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2350 Wilkens ave
(c) Hospital or institution: — — 20-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2350 Wilkens ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME James R. Thrush

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma M. Thrush
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Aug. 2-1878

8. AGE: Years	Months	Days	If less than one day
70	4	15	hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business B+O.R.R. yards.

FATHER
12. Name Francis J. Thrush
13. Birthplace Md

MOTHER
14. Maiden Name Mary Ridgeway
15. Birthplace Md

16 (a) Informant Mrs. Emma M. Thrush
(b) Address 2350 Wilkens ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Baltimore Md

18 (a) Funeral director Geo L. Beyer Jr
(b) Address 1512 Hollins st

19 DEC 21 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1948 at 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1948 to Dec 17 1948 and that I last saw him alive on Dec 16 1948

Immediate cause of death Cardiac failure — Duration .....
Due to Arteriosclerotic Cardio-Vascular Disease .....
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Albert Seagmiller M.D.
Address 1724 W. Lombard St Date signed 12/18/48

VS 150

X

69649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G69649

Please answer all questions as carefully supplied. Every question is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4670 Park Heights Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4670 Park Heights Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna M. High.

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Widow

6 (b) Name of husband or wife William High
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown (About 1880)

8. AGE: Years	Months	Days	If less than one day
About 68	?	?	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name John Jamison,
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Marria L. Jones,
15 Birthplace Baltimore, Md.

16 (a) Informant Mr. Joseph Ramos,
(b) Address 3627 Greenmount Ave.,

17 (a) burial (b) Date thereof 12/21/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Maria Cemetery,
Location Towson, Balto. Co. Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.,

19 (a) Dec 21 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19, 1948 at 10. A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1947 to Dec 19 1948, and that I last saw her alive on Dec 13 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	Sudden
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. L. DeBaldini M. D.
Address 4723 Park Heights Date signed

V S 190

G69650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G69650 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution: Good Samaritan Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1539 Argyle Ave (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country —

3 (a) FULL NAME Grace Franklin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-10-1907

8. AGE: Years	Months	Days	If less than one day
41	8	8/7	hr. min.

9. Birthplace Jamestown, Va
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Emanuel Winston
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Winston
15. Birthplace Va.

16 (a) Informant Emanuel Franklin
(b) Address 914 N. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md.

18 (a) Funeral director Chas. R. Law
(b) Address 802 Madison Ave

DEC 21 1948

19 (a) — (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19/48 19 , at 9:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3/48 19 to 12/19 1948.
and that I last saw h[illegible] alive on 12/14/48

Immediate cause of death Cancer Return — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm D Lomax M.D.
Address 402 Edmondson Ave Date signed 12/16/48

VS 153

X

G96:51
AB-116906

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

520

Registered No. G696:51

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?

8. AGE: Years	Months	Days	If less than one day
85 ?			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12-21-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Frances A. Kemaley
(b) Address 578 W. Biddle St.

19 (a) DEC 21 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18- 1948, at 12.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26- 1948, to 12-18- 1948, and that I last saw h 9r alive on 12-18- 1948.

Immediate cause of death	Duration
Arteriosclerotic Heart disease	?
Due to Generalized arteriosclerosis	?
Due to	
Other Conditions Hypertrophy of Kidneys; Cystitis	?

(Include pregnancy within 3 months of death)

Date of operation 11-24-48 12-3-48

Major findings of operation: Cystitis

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dwight A. Pitchford M. D.
Address 1410 Eastern Ave Date signed 12-20-48

V S 150

93

G696552

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G696552

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1323 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1323 Eutaw Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Helen Rolfe Hopkins Thom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	widowed

6 (b) Name of husband or wife Hunt R. Mayo Thom
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23 1869

8. AGE: Years	Months	Days	If less than one day
79	0	26	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph S. Hopkins
13. Birthplace P.A. Co. Md

MOTHER
14. Maiden Name Annette Hicks Hopkins
15. Birthplace D.C.

16 (a) Informant Mrs. Robt. Dixon Bartlett
(b) Address 200 Cedarcroft Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21 1948 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director Henry W. Jenkins Sons Co.
(b) Address 4905 York Road

19 DEC 21 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1948, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1948, to 19 Dec. 1948, and that I last saw her alive on 14 Dec 1948.

Immediate cause of death: Acute pulmonary edema — Duration: 1/2 hour
Due to Arteriosclerosis Hypertension
Due to Hypertensive cardio-vascular disease.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County), (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. F. Haussberger M.D.
Address 1207 Eutaw Pl. Date signed 20 Dec '48

VS 150

696553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

696553 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 St. Dunstans Rd
(c) Hospital or institution:
—
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 da
(e) Length of stay in Baltimore (yrs., mos., or days) 14 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town White Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Catherine Wiley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John F. Wiley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1868

8. AGE: Years	Months	Days	If less than one day
80	6	9	hr. min.

9. Birthplace Madonna, Harford County, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Franklin Pennington
13. Birthplace USA

MOTHER
14. Maiden Name Eliza Arthur
15. Birthplace USA

16 (a) Informant Mrs. Maude Hunter
(b) Address 616 St. Dunstans Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22 - 1948 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location White Hall (Road)

18 (a) Funeral director Howard S. Mahlon
(b) Address White Hall Md

19 (a) DEC 21 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1948, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Dec 1948, and that I last saw h.e alive on December 20 1948.

Immediate cause of death	Duration
Cerebral arteriosclerosis	2 yrs.
Due to Arteriosclerosis, generalized disease	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederick D. Vollmer M. D.
Address 6100 York Road Date signed 12-20-48

VS 180

Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

669854 Certificate Corrected 1-7-49 ✓ 577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669854

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hos.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9da
(e) Length of stay in Baltimore (yrs., mos., or days) 9da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Wicomico
(c) City or town Salisbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. Chesapeake Heights
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Taylor Mr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Jeanne Marie Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1921

8. AGE: Years	Months	Days	If less than one day
27	7	15	hr. min.

9. Birthplace Salisbury Md.
(Town, county, and state)

10. Usual Occupation Clerk Traffic Mgr
11. Industry or business

FATHER
12. Name Roy S Taylor
13. Birthplace Maryland

MOTHER
14. Maiden Name Helen O. Collins
15. Birthplace Delaware

16 (a) Informant Mrs. Jeanne Taylor
(b) Address R.D. #1 Salisbury, Md.

17 (a) Burial - Private (b) Date thereof 12-23-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parsons Cemetery
Location Salisbury Md

18 (a) Funeral director Holloway & Co.
(b) Address Salisbury, Maryland

19 (a) DEC 21 1948 Huntington Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Dec. 1948, at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Dec 1948, to 20 Dec 1948, and that I last saw h[illegible] alive on 20 Dec 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Brain Stem Neoplasm Type Undetermined	
Due to	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation 20 Dec 48

Major findings of operation: Neoplasm area of medulla

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George H Smith M. D.
Address University Hospital Date signed 20 Dec

VS 153

G696:55

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

Registered No. G696:55

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins 7-8

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. 2108 East Madison (If rural give location)
(d) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry C. Broughton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1865

8. AGE: Years 83 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Broughton
13. Birthplace Md.

MOTHER
14. Maiden Name Mry J. Treadway
15. Birthplace Md.

16 (a) Informant Alice M. Mortz
(b) Address 2108 Madison

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Ullrich Funeral Home

18 (a) Funeral director 2008 Orleans St.
(b) Address

19 (a) DEC 21 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19/48 19 11:35 P.M

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Strangulation

Due to

Other Conditions Mental Depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/19/48 at 6:00 P.M.
(b) Where did injury occur? 2106 East Madison Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hung self with clothesline

23. Signature John R. Sabra, M.D. Medical Examiner.
Date signed 12/20/48

VS 151

696:56

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

696:56 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2340 E Fayette
(c) Hospital or institution:
6-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 E Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice P Collins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Edward Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1895

8. AGE: Years 51 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Joseph Swardowski
13. Birthplace Poland

MOTHER
14. Maiden Name Dont Know
15. Birthplace

16 (a) Informant Mrs Helen Ruby
(b) Address 2338 E Fayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) DEC 21 1948 (Date rec'd by Reg.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1948, at 10 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 26 1948. to Dec-20 1948. and that I last saw her alive on Dec 17 - 1948.

Immediate cause of death Inoperable Carcinoma Cervix with pelvic metastasis — Duration 10 mos.

Due to

Due to

Other Conditions Acute Cystitis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature [illegible] M. D.
Address 15 W. Mulberry St Date signed 12/20/48

VS 150

X

6696:57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 6696:57

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 N. Glover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 808 N. Glover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nikolaus Lehmeyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna B. Lehmeyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1865

8. AGE: Years 83 | Months 2 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Gardner - retired

11. Industry or business

FATHER
12. Name Don't Know
13. Birthplace Don't know

MOTHER
14. Maiden Name Don't Know
15 Birthplace Don't Know

16 (a) Informant Mrs. Anna Lehmeyer
(b) Address 808 N. Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) DEC 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1948, at 6:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1948 to Dec 20 1948, and that I last saw h/M alive on Dec 19 1948.

Immediate cause of death: cerebral Hemorrhage arteriosclerosis - generalized — Duration: 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Klemer M. D.
Address 2622 E. Monument St Date signed 12/20/48

VS 199

G696:58

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

G696:58 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3471 Mayfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3471 Mayfield Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys A Horstmann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Andrew Horstmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar 5 1912

8. AGE: Years	Months	Days	If less than one day
36	9	13	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Landsdowne Distilling

FATHER
12. Name George D Leonard
13. Birthplace Balto

MOTHER
14. Maiden Name Adelphia Urbach
15 Birthplace Balto

16 (a) Informant Andrew M Horstmann
(b) Address 3471 Mayfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Balto Co Md

18 (a) Funeral director Uhl Funeral Home
(b) Address 2008 Orleans St

19 (a) [illegible] (b) Pennington Wills

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1948, at 8 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1945 to 12-18-1948, and that I last saw her alive on 12-18 1948.

Immediate cause of death	Duration
Myxoma of pharynx and palate.	9 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Nelson C. Carey M. D.
Address 2117 Belair Rd (Date signed 12-20-48

VS 150

X

66963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66963

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city limits write RURAL and give town)
(d) Street No. 1133 Valley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (PETER LORRIO) PIETRO LOIERO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Mary Geralico

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1890

8. AGE: Years 58 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Core Maker

11. Industry or business

FATHER
12. Name Alphonse Loiero
13. Birthplace Italy

MOTHER
14. Maiden Name Philamena Cornavelle
15. Birthplace Italy

16 (a) Informant Miss Loiero
(b) Address 1133 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St.

19 (a) DEC 21 1948 (Date rec'd by registrar) (b) Huntingtown, Maryland Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1948, at 9 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypostatic pneumonia,
Fracture of skull with intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-3-48 at About 7:10 p. M.
(b) Where did injury occur? Charles Street, 30' nr. of Pa. Station
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury "Hit and Run"

23. Signature Carl L. Kruger M.D.
Medical Examiner.

Date signed 12-20-48

X

G69660

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

G69660 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Catalphia Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Lola H. Inui Inui

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 5, 1918

8. AGE: Years	Months	Days	If less than one day
30	7	15	hr. min.

9. Birthplace Utah (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Iwa Inui
13. Birthplace Japan

MOTHER
14. Maiden Name Taki Inui
15. Birthplace Japan

16 (a) Informant Mrs. Taki Inui
(b) Address 4700 Catalphia Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/23/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Greenmount & Oliver St.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 609 Harford Road

19 (a) DEC 21 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Dec 1948, at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Dec 1948 to 20 Dec 1948 and that I last saw her alive on 20 Dec 1948.

Immediate cause of death Bilateral atelectasis & pleural effusion & mediastinal shift

Due to Massive pleural effusion & mediastinal shift

Due to Pulmonary Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: Confirmatory

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. P. Young M.D.
Address West Balto. Hosp. Date signed 23 Dec 48

VS 150

G69661

JL - 124641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69661

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore Citys Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Hornberger.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife OHLIE HORNBERGER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1880

8. AGE: Years	Months	Days	If less than one day
68	8	15	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation –

11. Industry or business –

FATHER
12. Name George Brown
13. Birthplace ?

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem Co.
Location

18 (a) Funeral director Bernard C. Hasler
(b) Address 121 E. Mt. St.

19 (a) DEC 21 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1948, at 6.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1948, to Dec. 20 1948, and that I last saw h er alive on Dec. 20, 1948.

Immediate cause of death	Duration
Cerebral Vascular Accident	
Due to Hypertensive Cardio-Vascular Disease.	
Due to	
Other Conditions Contusion of L. diaphragm (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kuhlen M.D.
Address Balto City Hosp Date signed Dec 20 48

VS 150

G69662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G69662 Registered No.

Please write clearly and legibly. Use black ink. Do not use pencil. Physician's certification of cause of death must be clear and legible.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: St. Agnes Hospital 28-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5310 Chandler Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret C Stengel

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 11 1895

8. AGE: Years	Months	Days	If less than one day
53	9	8	hr. min.

9. Birthplace Oregon (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name John STENGEL
13. Birthplace GERMANY

MOTHER
14. Maiden Name Margaret IMMEL
15. Birthplace GERMANY

16 (a) Informant MISS MARGARET F. IMMEL
(b) Address 3025 IONA AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 23-48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEM.
Location FREDERICK AVE

18 (a) Funeral director Wm Chas A. G. Rohde
(b) Address 2327 Edmondson Ave

19 DEC 21 1948 (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19th 1948, at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/30 19 48 to 12/19 19 48, and that I last saw her alive on 12/19 19 48.

Immediate cause of death	Duration
(a) Cardio Respiratory failure	1 week
(b) Uremia	
Due to (c) Metastatic Carcinoma Ilyo pelvis	
Due to	over
Other Conditions Hydronephrosis Carcinoma Cervix	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: Acc

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo A Magruder M. D.
Address St Agnes Hosp Date signed 12/20/48

VS 150

X

G696653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G696653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 27-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 Batavia Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES P. TAYLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Sarah Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15, 1871

8. AGE: Years	Months	Days	If less than one day
77	4	4	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant John Taylor
(b) Address 3209 Batavia Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Bernard C. Harle
(b) Address 121 E. West Street

19 DEC 21 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1948, at 8.05 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH A S C V D

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Boyer M.D. Medical Examiner
Date signed December 20, 1948

VS 151

G6966T

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

Registered No. G6966T4

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Overlea
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5839 Westwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALMIRON DURAND GRAFTON (GRAFTEN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 30 1921

8. AGE: Years	Months	Days	If less than one day
27	8	20	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Assembly Chemical Plant
11. Industry or business Balto., Md.

FATHER
12. Name N. Almiron Graften
13. Birthplace Md.

MOTHER
14. Maiden Name M. Willene Freddwell
15. Birthplace Baltimore, Maryland

16 (a) Informant: Mrs. Elizabeth Grafton
(b) Address 5839 Westwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Baltimore, Md

18 (a) Funeral director L. J. Peck
(b) Address 5305 Harford Rd.

19 DEC 21 1948 (Date rec'd by registrar) Registrar for Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19, 1948 at 6:30 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet Wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 18/48 1:35 A.M.
(b) Where did injury occur? 5839 Westwood Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Earl L. Riggs M.D. (Medical Examiner)
Date signed 12/21/48

G69665 ✓ G69665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 E. Lafayette Ave #3 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Wentzler

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Robert Wentzler
6 (c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): July 8, 1902

8. AGE: Years: 46 | Months: 5 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Austria (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Joeseph Sauhammel
13. Birthplace: Austria

MOTHER
14. Maiden Name: Theresa Musser
15. Birthplace: Austria

16 (a) Informant: Mr Robert Wentzler
(b) Address: 1834 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE & BROADWAY

19 (a) 12/21/48 (Date rec'd by registrar) (b) Turnbington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1948, at 10 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1948 to 12/20 1948, and that I last saw her alive on 12/20 1948

Immediate cause of death: Cardio-respiratory failure — Duration:
Due to: Pulmonary edema
Due to: Hypertensive Heart Disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Charles J. Blazek, M.D.
Address: Maryland General Hospital
Date signed

Blazek

VS 150

569666

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

Registered No. 669666

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 North Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH J. OTTAVIANO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1885

8. AGE: Years	Months	Days	If less than one day
63	4	22	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business Produce Dealer

FATHER
12. Name Nicola Ottaviano
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant: Mr. & Mrs. Fred Himler
(b) Address 3039 Mayfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) 12/21/48 (Date rec'd by registrar) Registrar for Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1948, at 10.15 M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Due to Congestive heart Failure.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D. Medical Examiner

Date signed December 20, 1948

VS 151

669657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

669657 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3154 Leeds St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3154 Leeds St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeremiah James Pumphrey.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1883.

8. AGE: Years	Months	Days	If less than one day
65	5	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name John Pumphrey
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Sarah Wickes.
15. Birthplace Baltimore, Md.

16 (a) Informant John H. Wickes.
(b) Address 3154 Leeds St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21, 1948. (month) (day) (year)
(c) Cemetery or crematory Western Star.
Location Catonsville, Md.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) DEC 21 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1948, at 11.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948. to Dec 16 1948. and that I last saw him alive on Dec 14 1948.

Immediate cause of death Arteriosclerotic Heart Disease — Duration 2 y

Due to Generalized Arteriosclerosis

Due to

Other Conditions Malnutrition (Severe)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert L. Moseley Jr. M. D.
Address 2024 Madison Ave Date signed 12/19/48

VS 150

Moseley X

G69668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G69668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Virginia Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY FRANK SCHEFFLER

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-7465

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1896

8. AGE: Years	Months	Days	If less than one day
52	1	7 6	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business Cooper, Kimball & Tyler

FATHER
12. Name Frank Scheffler
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant: Margaret M. Horn
(b) Address 614 Virginia Ave Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Blvd.

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave. Essex

19 DEC 21 1948 (b) Huntington Williamsport Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1948, at 11.20a M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 20 Dec 48

GS9669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. GS9669

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 Bevans
(c) Hospital or institution:
23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Bevans (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida James

3 (b) If veteran, name war ----- | 3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/15/1878

8. AGE: Years	Months	Days	If less than one day
70	-	4	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Handy
13. Birthplace Md

MOTHER
14. Maiden Name Ida ?
15. Birthplace Md

16 (a) Informant Mary Kent
(b) Address 931 Druid St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Ct.
Location Baltimore, City.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W. Montgomery Street

19 DEC 21 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1948, at 8 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 12/13/48 to 12/19/48 and that I last saw h[im] alive on 12/19/48

Immediate cause of death Bronchopneumonia (Influenza) — Duration 2 days. 3 weeks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be changed statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. George Shelton
Address 908 S. Broadway Date signed 12/20/48

VS 150

G69670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G69670

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 546 W. Conway Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 546 W. Conway Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest T. Henson

3 (b) If veteran, name war -------

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/9/1896

8. AGE: Years 52 | Months 11 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business Paper Company

FATHER
12. Name Richard Henson
13. Birthplace Md

MOTHER
14. Maiden Name Sadie ?
15. Birthplace Md

16 (a) Informant Charles E. Moore (B)
(b) Address 627 N. Stockton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Ct.
Location Baltimore, City

18 (a) Funeral director Samuel Berman
(b) Address 108 W. Montgomery Street

19 (a) (b) Tuntington Williams, M.D. Registrar

DEC 21 1948

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1948 at 3-P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1948 to Dec 10 1948.
and that I last saw h[illegible] alive on Dec 16 1948.

Immediate cause of death Endocarditis

Due to

Due to

Other Conditions Bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James C. Carper M. D.
Address 1016 E. Lexington Date signed

X

G69671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G69671

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412-N. Register st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412-N. Register st. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Gray

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-1-1881

8. AGE: Years 67 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore - Maryland (Town, county, and state)

10. Usual Occupation Homemaker

11. Industry or business

FATHER
12. Name Dick Huggin Gray
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Esther M. Harris
(b) Address 412-N. Register st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn - Md.

18 (a) Funeral director Holland Funeral Home
(b) Address 1621-Lund Hill ave

19 (a) DEC 21 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1948, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-1948 to 12-18-1948.
and that I last saw alive on 12-18-1948.

Immediate cause of death
Hemiplegia - Duration 1 wk
Due to Cerebral Arteriosclerosis 3 mos.
Due to Carcinoma of breast 2 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. L. Berry M. D.
Address 1420 E. Chase Date signed 12-20-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G699672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G699672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & John St.
(c) Hospital or institution: Hosp. Women of Md. 11
(d) Length of stay in hospital or inst. (~~years~~, or days) 5
(e) Length of stay in Baltimore (yrs., ~~mos. or days~~) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Madison Ave MADISON (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE ESTELLE BORDETTE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12 1884

8. AGE: Years	Months	Days	If less than one day
64	8	8	hr. min.

9. Birthplace Mt. Airy, Md. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name John Bordette
13. Birthplace ? Maryland

MOTHER
14. Maiden Name Martha Watkins
15. Birthplace ? Maryland

16 (a) Informant Patrick (Gertrude E. Bordette
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/48 (month) (day) (year)
(c) Cemetery or crematory Kemptown, Md.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 21 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1948, at 2.5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1948, to Dec 20 1948, and that I last saw her alive on Dec 12 1948.

	Duration
Immediate cause of death Pneumonia, hypostatic	3 days
Due to Arteriosclerotic Hypertensive Cardiovascular disease	1+ yrs.
Due to	
Other Conditions Pregnant, 4 mo. fetal, due to embolus popliteal artery.	4 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Mark E. Holt, J. M. D.
Address Hosp. Women, Md Date signed 12/20/48.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G69673 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 Englewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin F. Bealor

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ada C. Kroll Bealor

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 21, 1891

8. AGE: Years 57 | Months 1 | Days 27 | If less than one day: hr. min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation: Supt., Ordinance Plant

11. Industry or business: U. S. Government

FATHER
12. Name: Samuel K. Bealor
13. Birthplace: Markelsville, Pa.

MOTHER
14. Maiden Name: Emma Sipe
15. Birthplace: Pa.

16 (a) Informant: Mrs. Ada C. Bealor
(b) Address: 2016 Englewood Ave., Woodlawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 21 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Dec. 1948, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Wm. H. Kammer, Jr. M.D. Medical Examiner.
Date signed 18 Dec. 48

VS 181

696774 VS - 122229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 138

Registered No. 696774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 N. Pine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Melvin Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Hattie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1902

8. AGE: Years	Months	Days	If less than one day
46	6	20	hr. min.

9. Birthplace Ga.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Will Walker
13. Birthplace Ga.

MOTHER
14. Maiden Name Mattie Sikler
15. Birthplace Ga.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory Cedartown
Location Cedartown, Ga.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) DEC 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 19 48 at 7.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19 19 48 to Dec. 17 19 48, and that I last saw h im alive on Dec. 17 19 48

Immediate cause of death Hemorrhage from lung — Duration 5 min.

Due to Far Advanced Pulmonary Tuberculosis — 4 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: DS Donor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M. D.
Address Baltimore City Hosp. Date signed 12-18-48

V S 150

X

G69675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

Registered No. G69675

Physicians: please write the causes of death clearly and legibly. Please see that every item is properly answered. Do not allow any space to remain unfilled unless it is especially important. Please see that every item is correctly supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5120 Liberty Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ——
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5120 Liberty Heights Av
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME DOMINICK TAMBURO

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Frances Tamburo
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Dec. 28th 1869

8. AGE: Years	Months	Days	If less than one day
78	11	21	____ hr. ____ min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired * Prop.
11. Industry or business Confectionary Store

FATHER
12. Name Dominick Tamburo
13. Birthplace Italy

MOTHER
14. Maiden Name Rose Marzallo
15. Birthplace Italy

16 (a) Informant S. S. Tamburo
(b) Address 4404 Belveiw Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director Phillips Tamburro
(b) Address 4510 Liberty Heights Ave.

19 (a) DEC 21 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December, 19th 1948, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1st 1945 to Dec. 19 1948. and that I last saw him alive on Dec. 16 1948.

Immediate cause of death
11. Cerebral Hemorrhage — Duration 5 Days

Due to

Due to

Other Conditions Arterio Sclerosis — 5yrs.
Heart Disease
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Heights Ave. Date signed

VS 150

G69676 GM. 125456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G69676

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
B ltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town Baltimore Edgemere
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 Gross Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Smith (Mother Emma Smith)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 18-1948

8. AGE: Years	Months	Days	If less than one day
			11 hr. 21 min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Smith
13. Birthplace PA.

MOTHER
14. Maiden Name Emma Roberts
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave. 9 AM

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 12/21/48 (month) (day) (year)
(c) Cemetery or crematory Balto. City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) DEC 21 1948 (b)
(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 19- 1948, at 6.30AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12- 18- 1948, to 12- 19- 1948, and that I last saw him alive on 12- 19- 1948.

Immediate cause of death	Duration
Intrapulmonary Hemorrhage	2-3 hrs.
Due to Unknown Cause	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy Intrapulmonary Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Fetter, M.D.
M. D.
Address Baltimore City Hospitals Date signed 12-20-48

161c

G69677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G69677 Registered No.

Please type or print plainly with pen and use only black or blue-black ink. Be sure that the cause of death is entered clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2225 Ruskin Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 +
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2225 Ruskin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Hornstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mamie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/28

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Lemon
13. Birthplace Romania

MOTHER
14. Maiden Name Sarah
15. Birthplace Romania

16 (a) Informant Mamie Hornstein
(b) Address 2225 Ruskin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-48 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) DEC 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20-1948, at 8 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948, to Dec 20 1948, and that I last saw h alive on Dec 20 1948.

Immediate cause of death Coronary Thrombosis (2nd attack) — Duration 24 hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherman Cooper M. D.
Address 2301 Eutaw Place Date signed 12/24/48.

VS 150

G69678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 Myrtle Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Fisher - 2749468

3 (b) If veteran, name war	3 (c) Social Security Account No.
World I	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S.

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4-1891

8. AGE: Years	Months	Days	If less than one day
57	6	12/14	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name P. Hammond
13. Birthplace Md.

MOTHER
14. Maiden Name Lyia Monroe
15. Birthplace Md.

16 (a) Informant Lillie Millard
(b) Address 917 Myrtle Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-22-48 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location City

18 (a) Funeral director Samuel N. Sullivan Jr.
(b) Address 211 N. Arlington Ave.

19 (a) [illegible] Washington Williams M.D. Registrar
DEC 23 by 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1948, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1948 to 12/18 1948, and that I last saw h[illegible] alive on 12/16 1948.

Immediate cause of death	Duration
Hypertensive Cardio Vascular Disease	7
Due to	
Due to	
Other Conditions Pulmonary congestion (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Garner
Address 253 Carey St Date signed 12/27/48

V S 190

X

G69679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G69679

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 846 Hampden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 846 Hampden St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Geneva W. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Jonathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1909

8. AGE: Years 39 | Months – | Days 26 | If less than one day hr. min.

9. Birthplace Bishopville, S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Elliott J. Nilage
13. Birthplace Bishopville, S.C.

MOTHER
14. Maiden Name Ida Jane Lucas
15. Birthplace Bishopville, S.C.

16 (a) Informant Mr. Jonathan Smith
(b) Address 846 Hampden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Balto. Co. Md.

18 (a) Funeral director Mrs. George A. Hallane
(b) Address 1631 Druid Hill Ave.

19 DEC 21 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20/48 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10/48 to 12/20/48 and that I last saw him alive on 12/19/48

Immediate cause of death Cerebral Hemorrhage

Due to Apoplexy

Due to Paralysis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burke Rawlins M. D.
Address 2124 Druid Hill Ave Date signed 12/20/48

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 19

669680 Registered No.

Please write clearly and legibly. Use ink or indelible pencil.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Johns Hopkins Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emily Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Walter ?

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr) 11-26-10

8. AGE: Years 37 | Months - | Days 25 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wesley Knight
13. Birthplace Va.

MOTHER 14. Maiden Name Emily Rachers
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A County

18 (a) Funeral director Mrs Portia Elliott
(b) Address 1293 N. Caroline St

19 (a) DEC 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1948 at 12 52 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1948 to 12/21 1948 and that I last saw h[illegible] alive on 12/21 1948.

Immediate cause of death: Acute hemolytic anemia — Duration: 3 mos.

Due to: Undetermined cause

Due to: —

Other Conditions: Tuberculosis of lymph glands. (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bertram E. Sprague
Address JOHNS HOPKINS HOSPITAL Date signed M. 12 D. 21/48

VS 150

737

G69681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47a

Registered No. G69681

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4105 Kinsway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-4
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4103 Kinsway (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET C. DOHONY

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Widowed

6 (b) Name of husband or wife Thomas Dohony
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1864

8. AGE: Years	Months	Days	If less than one day
84	8	23	24 hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name James Whelan
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Elizabeth Ackenback
(b) Address 4103 Kinsway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 11 E. Mt. Royal Ave

19 (a) DEC 21 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 19 48 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 8, 19 48 to Dec. 18 19 48 and that I last saw here alive on Dec. 18, 19 48.

	Duration
Immediate cause of death Toxic absorption	2 days
Due to Carcinoma of Larynx	1 year.
Due to	
Other Conditions Arteriosclerosis	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael J. Dausch M.D.
Address 1 W. Aveska Ave Date signed 12/21/48

VS 150

G69682

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G69682 Registered No. 54a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge (If outside city or town limits, write RURAL and give town)
(d) Street No. Montgomery Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Richmond (Charles Edmond Richmond)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-03-1061

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Ann Lee Richmond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1876

8. AGE: Years 72 | Months 1 | Days 8 | If less than one day: hr. min.

9. Birthplace: Union S. C. (Town, county, and state)

10. Usual Occupation: Executive Retired

11. Industry or business: Coca Cola Co.

FATHER
12. Name: Benjamin Franklin Richmond
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Louisa Moore
15. Birthplace: South Carolina

16 (a) Informant: Mrs. Anne L. Richmond, wife
(b) Address: Montgomery Rd., Elkridge, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/22/48 (month) (day) (year)
(c) Cemetery or crematory: National Memorial Park, Falls Church, Va.
Location:

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto. Md.

19 (a) DEC 21 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1948, at 7:58 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1948, to Dec 20 1948, and that I last saw him alive on Dec 20 1948

Immediate cause of death	Duration
Respiratory Failure	
Due to Extension of Malignancy Glioblastoma Multiforme	
Due to GLIOBLASTOMA MULTIFORME	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. A. Peterson M. D.
Address University Hosp. Date signed 12-20

VS 150

G69683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69683

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 Ashland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Lewis Schmidt) LOUIS C. SCHMIDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Loretta Schmidt

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 8, 1886

8. AGE: Years 62 (63) | Months 5 | Days 12 11 | If less than one day ____ hr. ____ min.

9. Birthplace California (Town, county, and state)

10. Usual Occupation Woodworker

11. Industry or business Packing Box Industry

FATHER
12. Name Louis Schmidt
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Loretta Schmidt
(b) Address 2000 Ashland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Maryland

18 (a) Funeral director FRANK CVACH & SON
(b) Address 900 N. Chester Street

19 (a) DEC 21 1948 (Date rec'd by registrar) (b) Huntington Hillsboro, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19/48 19 . 5:05p M

21. I certify that I took charge of the remains described above, held an Autopsy (Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis, M.D. Medical Examiner.
Date signed 12/20/48

VS 151

669584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

669584 Registered No.

1. PLACE OF DEATH: 28-4
(a) Baltimore City, Maryland
(b) Street address 425 Chapel Gate Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Chapel Gate Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise M. Stritter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William Stritter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1862

8. AGE: Years	Months	Days	If less than one day
86	9	4	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Einolf
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Burk
15. Birthplace Germany

16 (a) Informant Lawrence Lubbers
(b) Address 425 Chapel Gate Lane

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/23/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) DEC 22 1948 (Date rec'd by registrar) (b) Burington for Williamsville Mo (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1948 at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to Dec 20 1948, and that I last saw h[illegible] alive on Dec 17 1948.

Immediate cause of death Cardiac Failure — Duration 3 months
Due to Hypertension Cardiovascular Disease
Due to
Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Townsend Jr. M. D.
Address 14 E. Eager St. Date signed 12/21/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

669685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

669685 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5005 Beaufort Ave.
(c) Hospital or institution:
27-19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5005 Beaufort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE E. MARSHALL

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	Female	White	Widow

6 (b) Name of husband or wife Howard F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1873

8. AGE: Years	Months	Days	If less than one day
75	11	2	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Holtz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Josephine (Unknown)
15. Birthplace Baltimore, Md.

16 (a) Informant Anna M. Marshall
(b) Address 5005 Beaufort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1948 19 at 2AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 19 48 to 12-20 19 48, and that I last saw h alive on 12-19 19 48.

Immediate cause of death	Duration
1 Arteriosclerosis	uncertain
Due to, Decompensation of	
2 Mitral Endocarditis	uncertain
Due to	
Other Conditions Senility	—

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. D. Esson M. D.
Address 7201 York Rd. Date signed 12-21-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

669686 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Joseph's Hospital 26-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 62 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore (If outside city or town limits write RURAL and give town)

(d) Street No. 311 S. Lehigh St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Elmira Olga Peterson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	wid.

6 (b) Name of husband or wife Mrs. F. Peterson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1884

8. AGE: Years	Months	Days	If less than one day
64 62	9		hrs. min.

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Chas Burgh

13. Birthplace Sweden

MOTHER 14. Maiden Name Mary Sutton

15 Birthplace Mass

16 (a) Informant Mr. Schroyer Peterson

(b) Address 311 S. Lehigh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24/48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Balto Md

18 (a) Funeral director Philip Stenwig Sons

(b) Address 2024 Eutaw St.

19 (a) DEC 22 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1948 at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1948 to Dec 21 1948 and that I last saw her alive on Dec 21 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ray C Pearson Jr. M. D.

Address St. Joseph's Hosp. Date signed 12/22/48

VS 150

83a

9687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G69687

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairmount & Broadway
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Edgemere
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2547 Lodge Forrest Rd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary D. Bailey
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife John Griffin Bailey
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) APRIL 29, 1920
8. AGE: Years 28 | Months 7 | Days 25 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Strawhan
15. Birthplace Md.

16 (a) Informant John Griffin Bailey
(b) Address 2547 Lodge Forrest Blvd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Pk.
Location Baltimore Md.
18 (a) Funeral director Philip Stuart Sons
(b) Address 2024 Orleans St
19 (a) DEC 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1948, at 10:45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 12/7 1948 to 12/14 1948, and that I last saw her alive on 12/14 1948

Immediate cause of death	Duration
Cardiac failure - Fracture of Neck of Femur	
Due to Congestive Heart Failure	
Due to Completed diagnosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. W. Huntington M.D.
Address Church Home Date signed 12/19/48

VS 150

69688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 69688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Rodgers Forge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Murdock Rd.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ada Ketler (Ada Elouise Ketler)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe.	White	Married

6 (b) Name of husband or wife William E. Ketler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/30/1900

8. AGE: Years	Months	Days	If less than one day
48	10	21	22 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Hwfe.
11. Industry or business

FATHER
12. Name Henry Weller
13. Birthplace Baltimore

MOTHER
14. Maiden Name Marie — —
15. Birthplace Baltimore

16 (a) Informant Wm E. Ketler
(b) Address 523 Murdock Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem Pk
Location Baltimore

18 (a) Funeral director Philip Stewart Sons
(b) Address 2024 Orleans St

19 (a) DEC 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/ 1948. at 7:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9/ 1948 to 12/21/1948. and that I last saw her alive on 12/21/1948.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to – Cachexia - malnutrition	
Due to Carcinomatosis	
Other Conditions –	

(Include pregnancy within 3 months of death)
Date of operation 1-26-48
Major findings of operation: Carcinoma of Colon - c metastasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Libby M. D.
Address St Joseph Hospital Date signed 12/21/48

VS 159

G69689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69689

124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Dillon

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1892

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace West Virginia (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER	12. Name Henry C Markoe
	13. Birthplace Mango County W. Va
MOTHER	14. Maiden Name Lord
	15. Birthplace Kent W. Va

16 (a) Informant Albert Dillon
(b) Address Pasadena Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-48 (month) (day) (year)
(c) Cemetery or crematory
Location Logan, W. Va

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eastern Place

19 DEC 22 1948 (Date rec'd by registrar) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21 1948, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 1948 to 12-21 1948 and that I last saw h & v alive on 12-21 1948.

Immediate cause of death	Duration
Cirrhosis of Liver	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gabler M. D.
Address Sinai Hosp. Date signed 12-22-48

VS 153

69690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 69690

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Frederick Rd. - 28
(If rural route location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Conaway

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-3550

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Evelyn Conaway
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 1/12/1900

8. AGE: Years 48 | Months 11 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Salesman ?

11. Industry or business

FATHER
12. Name Thomas Conaway (dec)
13. Birthplace Md.

MOTHER
14. Maiden Name Helen Swan
15. Birthplace Md.

16 (a) Informant Mrs Evelyn Conaway
(b) Address 1401 Frederick Rd. Catons

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23/48 (month) (day) (year)

(c) Cemetery or crematory Good Shepherd
Location Rogers Ave. Ellicott City

18 (a) Funeral director Easton Sons
(b) Address 608 Frederick Ave Catonsville

DEC 22 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1948, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1948, to 12/20 1948, and that I last saw h/m alive on 12/20 1948.

Immediate cause of death: Ruptured dissecting aortic aneurysm — Duration: 4-5 days ?
Due to: Atherosclerosis & hypertensive CVD
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Ruptured aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert J. Luckas, M.D.
Address St. Agnes Hosp. Date signed M. 12 D. 20/48

VS 153

69691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 69691

Important: Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2906 Brighton St
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Brighton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma T. McKinstry

3 (b) If veteran, name war

3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Chas W McKinstry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9 - 1882

8. AGE: Years	Months	Days	If less than one day
66	11	17	hr. min.

9. Birthplace Ga (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business House wife

FATHER
12. Name Summerfield Tucker
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name — Sullivan
15. Birthplace Unknown

16 (a) Informant Minnie C McKinstry
(b) Address 2906 Brighton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location

18 (a) Funeral director Charles P Towell
(b) Address 2427 Edmondson Ave

19 (a) DEC 22 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1948, at 5:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25, 1948 to Dec 20, 1948 and that I last saw h alive on Dec 20, 1948.

Immediate cause of death	Duration
Pneumonia, Orthostatic	2 days.
Due to Rt. Hemiplegia (Cereb. Hemorrhage)	Several
Due to Hypertension	Many years.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abram Goldman
Address 206 S. Gilmor St Date signed 12/21/48 M. D.

V S 150

Please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 669692

669692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY OF MD. 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DA
(e) Length of stay in Baltimore (yrs., mos., or days) 5 YR.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 E. BIDDLE ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Thomas Brodix

3 (b) If veteran, name war: 1ST WORLD WAR
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: DIVORCED
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) OCT. 10, 1890
8. AGE: Years 58 | Months 2 | Days 11 | If less than one day hr. min.
9. Birthplace WASHINGTON, D.C. (Town, county, and state)
10. Usual Occupation CATTLEMAN
11. Industry or business

FATHER
12. Name CHARLES R. BRODIX
13. Birthplace INDIANA

MOTHER
14. Maiden Name JOSEPHINE WEEDMAN
15. Birthplace ILLINOIS.

16 (a) Informant CHARLES R. BRODIX JR.
(b) Address 331 E. 47TH ST. N.Y.C. N.Y.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12 22 48 (month) (day) (year)
(c) Cemetery or crematory SPRINGFIELD MEETING HOUSE. Location JOBSTOWN, N.J.

18 (a) Funeral director HENRY W. JENKINS & SONS CO.
(b) Address 4905 YORK RD.

19 (a) DEC 22 1948 (Date rec'd by registrar) (b) Huntington Williamson M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1948 at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1948. to Dec 21 1948. and that I last saw him alive on Dec 21 1948.

Immediate cause of death: Congestive heart failure — Duration:
Due to: Arteriosclerotic cardiovascular renal disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Bruns M.D. M. D.
Address University Hospital Date signed 12/21/48

VS 150

X

B.C. 48-22272 ✓

66693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104a

Registered No. 66693

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Dolphin Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GILL LAVERNE EVANS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1948

8. AGE: Years	Months	Days	If less than one day
	2 mos.	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Theodore Evans
13. Birthplace Maryland

MOTHER
14. Maiden Name Helen Dates
15. Birthplace Maryland

16 (a) Informant Helen Evans
(b) Address 637 Dolphin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22, 1948 (Month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore, Maryland

18 (a) Funeral director Thomas E. Kelson
(b) Address 1303 Presstman Street

19 (a) DEC 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1948, at 1:30P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Uppen Respiratory Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner

Date signed 21 Dec 48

X

669694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

669694 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 N. Curley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN KRAUTSAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lena Krautsak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1871

8. AGE: Years	Months	Days	If less than one day
77	9	6	hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant: Mr. Henry Lentz
(b) Address 4125 Park Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilhelm Funeral Home
(b) Address 2007 Orleans St.

19 DEC 22 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1948, at 9.30a M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-21-48 at approx. M.
(b) Where did injury occur? 809 N. Curley Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? NO
(d) Means of injury Gas burners on but unlit

23. Signature Earl L. Royston M.D. Medical Examiner.
Date signed December 21, 1948

VS 151

X

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G699695 ✓ G699695 Registered No. 1248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 Shutter St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) All Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Shutter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella Walters Or (Ella Waters)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 28 1880

8. AGE: Years	Months	Days	If less than one day
68	11	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unkown
13. Birthplace Unkown

MOTHER
14. Maiden Name Unkown
15 Birthplace Unkown

16 (a) Informant Mrs Nillie Redmond
(b) Address 1439 W, Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 (a) DEC 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18- 1948 9.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23-48 to 12-18-1948 and that I last saw her alive on 12-18-1948

Cause of death

	Duration
Cirrhosis of liver	
and Jaundice	
Due to Arthritis & Nausitis	
Due to Exposure & work.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. R. Blake M.D. M. D.
Address 1603 N. Caroline Date signed
x Balto. 13 Md. 12/21/48

VS 150

696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 669696

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Montpelier St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
M. LEROY HERMINAU

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-24-2301

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Catherine A. Herminau

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20th, 1927

8. AGE: Years 21 | Months 3 | Days - | If less than one day hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)

10. Usual Occupation Assembly man

11. Industry or business Chevrolet Co.

FATHER
12. Name George A. Herminau
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rose Friese
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. M.L. Herminau
(b) Address 1610 Montpelier St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) DEC 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20th, 1948, at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1948 to 12/20 1948 and that I last saw h[illegible] alive on 12/19 1948.

	Duration
Immediate cause of death: Acute heart failure	
Due to: Lobar Pneumonia.	3 days
Due to:	
Other Conditions: Rheumatic Cardiovascular Disease.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L B Stevens
Address 3400 Eastern Ave. Date signed 12/22/48 M. D.

VS 150

Please answer all questions. Information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G69697.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G69697 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 Russell Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs.) mos., or days) 31

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Russell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW-1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Gertrude Johnson
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 1/20/1890

8. AGE: Years	Months	Days	If less than one day
58	10	29	hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Locke Insulator Co.

FATHER
12. Name Nathaniel Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Simms
15. Birthplace Md.

16 (a) Informant Gertrude Johnson
(b) Address 910 Russell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Ct.
Location Baltimore City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W. Montgomery Street

19 (a) DEC 22 1948 (Date received by Registrar) (b) Huntingtor Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1948 at 8-30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1948 to Dec 18 1948, and that I last saw him alive on Dec 18 1948.

Immediate cause of death Acute Lobar Pneumonia	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 12/18/48

VS 153

X

G69698

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G69698 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 FAYETTE ST.
(c) Hospital or institution: BON SECOURS HOSP. 6
(d) Length of stay in hospital or inst. (yrs. ~~mos.~~ ~~or~~ days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N. GLOVER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MRS. IRENE PYTRYKOW or Helen Irene PYTRYKOW.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, widowed, or ~~divorced~~
Female	W	

6 (b) Name of husband ~~or wife~~ Thomas Pytrykow
6 (c) If alive, give age Dec'd years

7. Birth date of deceased (mo., day, yr.) April 23 1889

8. AGE: Years	Months	Days	If less than one day
5960	7	28	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? CIOPEK
13. Birthplace ?

MOTHER
14. Maiden Name ?
15 Birthplace ?

16 (a) Informant Alexandria David
(b) Address 13 N. Glover street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-48 (month) (day) (year)
(c) Cemetery ~~cemetery~~ St Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A Weber
(b) Address 705 South ann st

DEC 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21 1948, at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1948 to 12/21 1948, and that I last saw her alive on 12/21 1948.

Immediate cause of death	Duration
Complete heart block	
Due to Coronary Occlusion	
Due to Arteriosclerosis (Primary)	
Other Conditions Hydro. thorax; decompensatio; Coronary insufficiency	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Womack M. D.
Address BON SECOURS HOSP. Date signed 12/21/48

VS 199

G69699 ✓ G69699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1936 Penrose Ave.
(c) Hospital or institution:

20 ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1936 Penrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE SOPHIE ROMOSER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1892

8. AGE: Years	Months	Days	If less than one day
56	5	13	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Salesla dy
11. Industry or business

FATHER
12. Name George F. Romoser
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Marguerite Horz
15. Birthplace Germany

16 (a) Informant Miss Caroline Romoser
(b) Address 1936 Penrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC 22 1948 (Date rec'd by registrar) (by) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1948 at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July, 1948 to Dec. 20, 1948, and that I last saw her alive on Dec. 18, 1948.

Immediate cause of death Cancer of the sigmoid and descending colon. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex. Bayer Jr. M. D.
Address 11 E. Chase Street Date signed 12.21.48

VS 150

X

669700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 669700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Kaufman
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-12-6150

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Laura Belle Kaufman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2/20/1871

8. AGE: Years	Months	Days	If less than one day
77	10	1	hr. min.

9. Birthplace Maryland. (Frederick) (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Wesley H. Kaufman
13. Birthplace W. Va.

MOTHER 14. Maiden Name Marian V. Oden
15. Birthplace Md.

16 (a) Informant Mr. John G. Kaufman, son
(b) Address 100 E. Pleasant St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1948 to 12/21 1948. and that I last saw him alive on 12/21 1948 10 a.m.

Immediate cause of death Cardiorespiratory failure — Duration
Due to pulmonary edema
Due to arteriosclerotic Ht. disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. L. Fenkell M. D.
Address Franklin Sq. Hospital Date signed 12/21/48

X

69701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 69701

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monumental and Rutland Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 Bliston N. Middle River
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James D. Wooden

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26. 1887

8. AGE: Years 61 | Months 7 | Days 25 | If less than one day 26 hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name Thomas C. Wooden

13. Birthplace Balto - Md.

MOTHER

14. Maiden Name Minnie M. Eches

15. Birthplace Balto - Md.

16 (a) Informant Mr. James D. Wooden

(b) Address 2902 Westfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location Taylor ave

18 (a) Funeral director Howard R. Bligh Jr

(b) Address 6009 Harford Road

19 (a) DEC 22 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22- 1948 at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21 1948, to 12-22 1948, and that I last saw him alive on 12-22 1948.

Immediate cause of death	Duration
Myocardial infarction	
Due to Posterior occlusion	
Due to	
Other Conditions Paget's disease (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gabel M. D.

Address Sinai Hosp Date signed 12-22-48

VS 193

669702

GM. 125222

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

669702 ✓ 92B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Nolan CT. Apt. A-1 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Blake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4 1929

8. AGE: Years	Months	Days	If less than one day
19	1	16	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Bolden
13. Birthplace MD.

MOTHER
14. Maiden Name Florence Blake
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location S. A. Co. Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount St. Balto
19 (a) DEC 22 1948 (Date received by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12- 20 - 1948, at 830 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12- 9- 1948 to 12- 20- 1948 and that I last saw her alive on 12- 20 - 1948.

Immediate cause of death Subacute bacterial endocarditis on mitral valve

Due to Rheumatic heart disease & mitral stenosis

Due to

Other Conditions Ball thrombus in right auricle.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David L. Maccini M. D.
Address Balto City Hosp Date signed 12-20-48

VS 150

G69703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G69703 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 S. FRANKLINTOWN RD.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S. FRANKLINTOWN RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H MANGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband ~~or wife~~ Late MINNIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 30, 1889

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	11 10	20 21		

9. Birthplace MARYLAND
(Town, county, and state)
10. Usual Occupation MEAT PACKER
11. Industry or business PROPRIETOR

FATHER
12. Name GEORGE MANGER
13. Birthplace GERMANY

MOTHER
14. Maiden Name ELIZABETH
15. Birthplace GERMANY

16 (a) Informant MR SYLVAN MANGER
(b) Address 124 S. FRANKLIN TOWN RD

17 (a) BURIAL (b) Date thereof DEC. 22, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Harry H. Weyler
(b) Address 4101 Edmondson Ave

19 (a) 22 1948 (b) Arrington Williams
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1944 to Dec. 20 1948 and that I last saw h[illegible] alive on Dec 19 1948

Immediate cause of death: Carcinoma of prostate — Duration 4 yrs
Due to: Carcinoma of Jejunum — 4½ mos
Due to: —
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation Aug - 1948
Major findings of operation: Carcinoma of prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 12-20-48 at 2 PM
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature]
Address 202 W Mosher Date signed 12-21-48 M. D.

VS 150

X

G69704 BALTIMORE CITY HEALTH DEPARTMENT G69704

CERTIFICATE OF DEATH

55B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: AZZIE MORRIS GRAVES

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 215-22-5174

4. Sex: M

5. Color or race: col

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1927

8. AGE: Years 21 | Months 10 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace NC (Town, county, and state)

10. Usual Occupation Seafarer

11. Industry or business

FATHER
12. Name Londry Graves
13. Birthplace NC

MOTHER
14. Maiden Name Mary Turner
15. Birthplace NC

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St. Huntington Williams, Md

19 (a) 12 22 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 19 48, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 48, to Dec. 20 1948, and that I last saw h im alive on Dec. 20 19 48.

Immediate cause of death: Osteogenic sarcoma (left femur)
A- Left hip disarticulation
Due to- (postoperative)
B- Generalized metastasis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: Unknown

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 12/21/48 M.D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item or information should be carefully supplied. The

G69705

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47c

G69705 Registered No.

Please write clearly and legibly. Use ink or indelible pencil. Do not use abbreviations. If the exact information is not known, give the best estimate possible. Do not leave any blanks. If none, write none.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2608 Puget Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2608 Puget Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sep. 5, 1900

8. AGE: Years 48 | Months 3 | Days 15 | If less than one day: hr. min.

9. Birthplace Richmond, Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Clinton Carter
13. Birthplace Virginia

MOTHER
14. Maiden Name Hester Hopson
15. Birthplace Virginia

16 (a) Informant Burial Nolan
(b) Address 522 Wilson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

DEC 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1948, at 3:25 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13, 1948, to Dec. 18, 1948, and that I last saw h[illegible] alive on Dec. 18, 1948.

Immediate cause of death Carcinoma, bronchogenic, left lung — Duration Unknown

Due to –

Due to –

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irvin B. Kenwick M. D.
Address 2351 Annapolis Ave Date signed 12/20/48

G69706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G69706 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 W. Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Earl Kimball

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Mail | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mazie Kimball

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1886

8. AGE: Years 62 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William L Kimball
13. Birthplace Annapolis Md.

MOTHER
14. Maiden Name Georgiana Richardson
15. Birthplace Annapolis Md.

16 (a) Informant Mazie Kimball
(b) Address 1116 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23, 1944 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

19 (a) DEC 22 1944 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30/44 19 to 12/19 1944.
and that I last saw h[illegible] alive on 12/19 1944.

Immediate cause of death — Duration
Uremia — 2 weeks
Due to Hypertensive Cardio Vascular-Renal Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 12/21/44

VS 193

Please write the cause of death clearly and legibly.

G69707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G69707

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3335 Romona Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3335 Romona ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael A. Mc Cluskey.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Widowed

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 23-1859

8. AGE: Years	Months	Days	If less than one day
89	6	27	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Mc Cluskey
13. Birthplace ?

MOTHER
14. Maiden Name Mary
15. Birthplace ?

16 (a) Informant Mrs Anna Mastcel
(b) Address 3335 Romona Ave

17 (a) Burial (b) Date thereof Dec 23-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto

18 (a) Funeral director Jos Hinr & Son
(b) Address 3001 Kentucky ave

19 (a) Huntington Williams, Md
(Date received by registrar) Registrar

DEC 29 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20/ 1948, at 6 Q M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1/ 1948 to 12/20/ 1948.
and that I last saw him alive on 12/17/ 1948.

Immediate cause of death Myocardial Insufficiency — Duration 2 Hrs

Due to Angina — 4 mos

Due to Arteriosclerosis — 1 year

Other Conditions Senility -

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Thomas White M. D.

Address 3809 Eastern Ave Date signed 12/24/48

VS 150

G69708 BALTIMORE CITY HEALTH DEPARTMENT G69708

CERTIFICATE OF DEATH

Registered No. 161B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution John Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Marys
(c) City or town Mechanicsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Richard Harding

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-4-48

8. AGE: Years	Months	Days	If less than one day
		16 17	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Harding
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Wathen
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (b) Date thereof DEC 22 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Joseph
Location Baltimore Md.

18 (a) Funeral director C. O. Bratteley Sons
(b) Address Leonardtown Md.

19 DEC 22 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1948, at 10 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1948 to 12-21 1948 and that I last saw him alive on 12-21 1948.

Immediate cause of death	Duration
Septicaemia in	
Due to newborn	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Parry M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 12-22-48

VS 150

G69709 ✓ G69709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1325 W. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 West Saratoga Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carter, Anthony

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-7138

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	colored	

6 (b) Name of husband or wife dead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-1-1863

8. AGE: Years	Months	Days	If less than one day
6 5	0	20	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Drug Emerson

FATHER 12. Name Anthony V. Carter, Sr.
FATHER 13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Harriett Jones
MOTHER 15. Birthplace Baltimore Md.

16 (a) Informant Edith Carter, Daughter
(b) Address 1325 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/48 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Baltimore County, Md.

18 (a) Funeral director Joseph A. Kibley
(b) Address 662 W. Barre St.
Livingston Williams, Mgr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21 1948, at 6 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-1948 to 12/21 1948
and that I last saw him alive on 12/21 1948

Immediate cause of death: Cardiac Decompensation
Due to Arteriosclerotic Hrt. D.
Due to diabetes mellitus
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Smith M. D.
Address 306 E. Eager St. Date signed 12/24/48

VS 180

G69710

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164a

G69710 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 16-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Didmens Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY LEONARD BRISCOE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/1/ 1900

8. AGE: Years	Months	Days	If less than one day
48	5	20	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Harry Briscoe
13. Birthplace Maryland

MOTHER
14. Maiden Name Lottie Briscoe
15. Birthplace Maryland

16 (a) Informant Agnes Johnson
(b) Address 1101 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Eugene Waters
(b) Address 661 W. Baltimore St

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1948, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to strangulation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 20/48 9 P.M.
(b) Where did injury occur? 1702 Didmens Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hung self with rope

23. Signature Earl [illegible] M.D. Medical Examiner
Date signed 12/20/48

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G69711 ✓ G69712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Ambassador Apts.
(c) Hospital or institution: none 12
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: none
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Ambassador Apts.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Clarence P. Triplett

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Christie H. Hartman

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 25, 1872

8. AGE: Years: 76 Months: 6 Days: 25 2h. If less than one day: hr. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation: Banker - retired

11. Industry or business:

FATHER
12. Name: William H. Triplett
13. Birthplace: Va.

MOTHER
14. Maiden Name: Harriet Templeman
15. Birthplace: Va.

16 (a) Informant: Mrs. Christie H. Triplett
(b) Address: Ambassador Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/48 (month) (day) (year)
(c) Cemetery ~~cemetery~~ Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place

19 (a) DEC 22 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20, 1948, at 9.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1947 to Dec. 20 1948, and that I last saw him alive on Dec. 20 1948.

Immediate cause of death: Internal Hemorrhage (?) — Duration: 4½ hrs.

Due to: a (No previous symptoms)

Due to:

Other Conditions: Coronary Thrombosis in Feb. 1947 — 22 mos.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work:
(e) Means of injury:

23. Signature: Robert W. Garis, M.D.

Address: 1103 St. Paul St. Date signed: 12/22/48

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G69712

LCH-97337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G69712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. no address
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN MICHAEL MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/29/1885

8. AGE: Years	Months	Days	If less than one day
62	11	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline ?
15. Birthplace Switzerland

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Rd.

18 (a) Funeral director John A. Keane
(b) Address 5[illegible] E. Fayette St. Washington or Williamsport, Md.

DEC 22 1948 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20/48 19 . at 1:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16/45 19 to 12/20/48 19 and that I last saw h im alive on 12/20/48 19

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to Uremia	2wk
Due to Arteriolar nephrosclerosis	2 yr.
Other Conditions General and Cerebral arteriosclerosis with left hemiplegia	14 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. S Stutzman M. D.
Address Balto - City Hosp. Date signed 12-21-48

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G69713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G69713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 - Division St
(c) Hospital or institution: Provident Hospital 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 - W. Lexington St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22 1899

8. AGE: Years 49 | Months 2 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, or state)

10. Usual Occupation Housemaid.

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va.

16 (a) Informant Alice Golphin
(b) Address 1624 - W. Lex. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn.
Location

18 (a) Funeral director A. Hebstead
(b) Address 918 - Druid Hill Ave.

19 (a) 1948 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 20 - 1948, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1948 to 12-20 1948 and that I last saw her alive on 12-20 1948.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 12-22-48

VS 150

G69714

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47

G69714 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Union Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY C. Larrimore

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 215-07-3426

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widower

6 (b) Name of husband or wife Irene G. Larrimore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1901

8. AGE: Years	Months	Days	If less than one day
47	6	11	hr. min.

9. Birthplace Stevenson, BaltimoreCo., Md. (Town, county, and state)
10. Usual Occupation Landscape Work
11. Industry or business Valley Landscape Co.

FATHER
12. Name Clyde C. Larrimore
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Buckingham
15. Birthplace Maryland

16 (a) Informant Harry C. Larrimore, Jr. (Son)
(b) Address Stevenson, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Leisters
Location Carroll Co., Maryland

18 (a) Funeral director BURGEE FUNERAL HOME
(b) Address 3621 Falls Road

(c) DEC 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1948, at 8.45a M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D. Medical Examiner.
Date signed December 21, 1948

G69715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G69715 Registered No.

30c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3835 Falls Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM F. (KATEN) KATES

3 (b) If veteran, name war ——

3 (c) Social Security Account No. 217-03-0466

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hester A. Kates

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1908

8. AGE: Years 40 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Cretaker

11. Industry or business: Maryland Casualty Co.

FATHER
12. Name: John J. Kates
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mabel F. Streeks
15. Birthplace: Maryland

16 (a) Informant: Mrs. Hester A. Kates
(b) Address: 3835 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Maryland

18 (a) Funeral director: BURGEE FUNERAL HOME
(b) Address: 3631 Falls Road

19 (a) DEC 22 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1948, at 4:48 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Central nervous system lues
Chronic alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner
Date signed 22 Dec 48

VS 151

G69716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G69716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1718 Ellamont St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 Ellamont St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Robinson Welmon

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles E. Welmon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1879

8. AGE: Years 69 | Months 2 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name William Tarbert
13. Birthplace Md.

MOTHER
14. Maiden Name Hannah Karr
15. Birthplace Md.

16 (a) Informant Charles E. Welmon
(b) Address 1718 Ellamont St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) DEC 29 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1948, at 9.00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948 to Dec 20 1948 and that I last saw h[illegible] alive on Dec 20 1948.

Immediate cause of death	Duration
Pulmonary Edema	4 da
Due to Mycocardial Insufficiency	4 da
Due to	
Other Conditions Diabetes	10 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Edw Dashiell M.D.
Address 57 23 St Paul St Date signed 12/22/48

VS 150

93E

G69717 BALTIMORE CITY HEALTH DEPARTMENT G69717
Registered No.

CERTIFICATE OF DEATH 54 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours
(c) Hospital or institution: 2000. W. Fayette St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7202. Woodson ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Nellie Pearce.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: James Pearce
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Dec 17. 1902.
8. AGE: Years: 46. Months: - Days: - If less than one day: hr. min.
9. Birthplace: Indiana. Clinton (Town, county, and state)
10. Usual Occupation: House Wife
11. Industry or business:

FATHER
12. Name: Peter J. Malley
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Pearl Smith
15. Birthplace: West Virginia

16 (a) Informant: James Pearce
(b) Address: 7202. Woodson ave

17 (a) Burial: (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Meadowridge Park
Location: Washington Blvd.

18 (a) Funeral director: Wendell Lippel
(b) Address: 312 S. Highland Ave

DEC 22 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12. 19 1948, at 9.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9. 1 1948 to 12. 19 1948 and that I last saw her alive on 12. 19 1948:

Immediate cause of death: Respiratory Failure — Duration:

Due to: Lung metastasis

Due to: Carcinoma of sp. cord. (Type undiagnosed)

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 9. 28. '48

Major findings of operations: Carcinoma ? Spinal cord.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: M. O'Callaghan. M. D.
Address: Bon Secour Hosp. Date signed: 12. 19. 48.

VS 150

G69718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 520

G69718 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Whitehall
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Roland Raphael Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1867

8. AGE: Years	Months	Days	If less than one day
81	01	4	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Enos Miller
13. Birthplace Maryland

MOTHER
14. Maiden Name Abigail Bussey
15. Birthplace Maryland

16 (a) Informant
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27 48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Whitehall Rd

18 (a) Funeral director Hynes & Machen
(b) Address Whitehall Rd

19 (a) Dec 22 1948 (Date received by Registrar) (b) Registered

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1948, at 5 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1948, to Dec 22 1948, and that I last saw him alive on Dec. 21 1948.

Immediate cause of death Cerebral embolism — Duration 10 min

Due to metastasis

Due to Kidney tumor — Jackson carcinoma

Other Conditions Benign prostatic hypertrophy.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation Adenocarcinoma Rt. kidney, liver & lung metastases

If autopsy: , coronary sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Charlton Gaylord M.D.

Address Union Memorial Hospital Date signed 12-22-48

X

G69719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69719

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G69720

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G69720 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 E. Fort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 E Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Dick

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	W.

6 (b) Name of husband or wife Beta.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-1872

8. AGE: Years	Months	Days	If less than one day
76	1	26	hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family
(b) Address Same

17 (a) B. (Burial, cremation, or removal) **(b) Date thereof** 12-24-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross.
Location Brooklyn.

18 (a) Funeral director James L. McCauley
(b) Address 130 E. Fort Ave.

19 (a) 12-22-1948 (Date rec'd by registrar) **(b)** Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/48 19 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dr. R. Sears M.D.
Medical Examiner.
Date signed 12/22/48

VS 151

G9721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104a

Registered No. G68721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Maryland General Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. (BLOSSEM) BLOSSER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1948

8. AGE: Years	Months	Days	If less than one day
	5	10	hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William H. Blosser
13. Birthplace West Virginia

MOTHER
14. Maiden Name Margaret Bland
15. Birthplace West Virginia

16 (a) Informant: Margaret Blosser
(b) Address 1311 Linden Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-48 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Maryland

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 St. Paul Street

19 DEC 22 1948 Victoria Williams M.D. Registrar
(Date received by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1948, at 3:10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Upper Respiratory Infection

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil H. Novak M.D.
Medical Examiner

Date signed 12-21-48

69722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45B

Registered No. 69722

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5415 Reisterstown Road
(c) Hospital or institution:

27-18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5415 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVE' ROBB McDANIEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5,1888

8. AGE: Years	Months	Days	If less than one day
60	8	16	hr. min.

9. Birthplace Kentucky (Town, county, and state)
10. Usual Occupation Horseowner and trainer
11. Industry or business

FATHER
12. Name David McDaniel
13. Birthplace Kentucky

MOTHER
14. Maiden Name Ida Platt
15. Birthplace Unknown

16 (a) Informant Mrs William Armour
(b) Address 135 Oakdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St.Paul St.

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1948 19 , at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19/ 1948 to 12/21/ 1948, and that I last saw him alive on 12/21/ 1948

Immediate cause of death Cancer of tongue — Duration 3 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard H. Ashbury M. D.
Address 6 E. Eager St. Date signed 12/24/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The entry item of information should be carefully supplied.

VS 150

0 X

669723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

669723 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 656 Cokesbury Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 656 Cokesbury Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph J. Pfister

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Esther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1868

8. AGE: Years 80 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Station Engineer - Retired
11. Industry or business Penna. R. R. Co.

FATHER
12. Name Jacob Pfister
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Henry A. Pfister
(b) Address 656 Cokesbury Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Elkridge, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1948, at 12:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4/ 1948, to 12/21/ 1948.
and that I last saw him alive on 12/20/ 1948.

	Duration
Immediate cause of death: Myocardial Insufficiency	unknown
Due to: Arteriosclerosis	unknown
Due to: ----------	
Other Conditions: -- --------	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. O. Mungovan M.D.
Address 401 E. 25th. St. Date signed 12/22/48

VS 150

Instructions: Every item of information should be carefully supplied. The ages are especially important. Physicians: please write the causes of death clearly and legibly.

9724

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

669724 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Riviera Beach - Pasadena Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Omar O. Ryan ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M.

6 (b) Name of husband or wife Isadora F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10th 1897

8. AGE: Years	Months	Days	If less than one day
51	10	11	hr. min.

9. Birthplace Md.
(Town, county and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Thomas Ryan
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Saunders
15. Birthplace Md.

16 (a) Informant Mrs. I. F. Ryan
(b) Address Riviera Beach, Pasadena P.O.

17 (a) Burial (b) Date thereof 12/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave. Extended.

18 (a) Funeral director William Cook & Inc
(b) Address 127 St. Paul St

19 (c) Date received by local registrar DEC 23 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21 1948, at 4 31/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21 1948, to 12-21 1948, and that I last saw h(M) alive on 12-21 1948.

Immediate cause of death Respiratory Failure

Due to Bilateral-apical pneumonia.

Due to Overwhelming toxemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney Johnson Venable M.D.
Address St. Agnes Hospital Date signed 12-21-48

VS 150

725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 669725

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3902 Spring dale Ave
(c) Hospital or institution:

15-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Spring dale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Morganstern

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry
13. Birthplace Russia

MOTHER
14. Maiden Name Freda
15. Birthplace Russia

16 (a) Informant husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-48 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 22 1948, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947, to 12-22 1948, and that I last saw h.e alive on 12-22 1948.

Immediate cause of death Central Hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. T. Cranky M. D.
Address 220 Liberty Hgts Date signed 12/22/48

VS 150

83a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

69726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 669726

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2204 Presstman
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 3

(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Presstman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Lustman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1885

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Freda
15. Birthplace Russia

16 (a) Informant Rose Lustman
(b) Address 2204 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-48 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel
Location Netzro

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Per Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22- 1948 at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1948 to 12/22 1948 and that I last saw him alive on 12/22 1948

Immediate cause of death Coronary Thrombosis — Duration 1 3 hrs

Due to Generalized Arteriosclerosis ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner

Address 2401 W North Ave Date signed 12/22/48

VS 150

G69727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G69727 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 N Carey St
(c) Hospital or institution:
Good Samaritan Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Ridgely St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Walter~~ Robert Hemmo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1874

8. AGE: Years	Months	Days	If less than one day
74	3		hr. min.

9. Birthplace Finland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Male Nurse

FATHER
12. Name (Unknown) Hemmo

13. Birthplace "

MOTHER
14. Maiden Name "

15. Birthplace "

16 (a) Informant Rev L. Holt

(b) Address 3447 Kenyon Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/24/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ St. Peters

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul St

19 (a) DEC 23 1948 (Date received by registrar) (b) Interment for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22/48 19 . at 9:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21/48 19 . to 12/22/48 . and that I last saw h[illegible] alive on 12/21/48

Immediate cause of death Myocarditis

Due to Arteriosclerosis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration
unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm F Holt M. D.

Address 4 W Edmondson Date signed 12/23/48

VS 159

Please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 669728

669728

Type or print in ink. Items must be answered carefully and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 N. Smallwood St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertie E. Arnold

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Pember S. Arnold
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Mar 24 1891

8. AGE: Years	Months	Days	If less than one day
57	8	27	hr. min.

9. Birthplace Dransville Va
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Henson Poole
13. Birthplace Va

MOTHER
14. Maiden Name Laura A. Nichols
15. Birthplace Va

16 (a) Informant Pember S. Arnold
(b) Address 104 N. Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 1948 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Mrs. Mrs. John W. Templeton Son
(b) Address 5311 Edmondson Ave

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1948 at 1 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1948 to Dec 22, 1948 and that I last saw her alive on Dec 22, 1948.

Immediate cause of death	Duration
Coronary Thrombosis	a few hours
Due to Arteriosclerotic Cardio-vascular disease	Many yrs.
Due to Hypertension	Many yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abram Goldman
Address 206 S. Gilmor St. Date signed 12/23/48 M. D.

V S 150

G69729

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G69729 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 411 W. Saratoga (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LORENZ PFLAUM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Katie Bransey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, k879

8. AGE: Years	Months	Days	If less than one day
69	11	-	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Water Front Warehouse

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Emma Collins (daughter)
(b) Address Severna Park Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmonson Ave.

18 (a) Funeral director F.A. Krause
(b) Address 1216 S. Charles St.

19 DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1948, at 10:12 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A.S.C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Bryan M.D. Medical Examiner.
Date signed 12/21/48

VS 151

X

69750 B.C. 48-16048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 69750

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 126 W. Camden Street
(c) Hospital or institution:

22 - 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 W. Camden St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME NANCY JEAN JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2, 1948

8. AGE: Years	Months	Days	If less than one day
	4	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Nathaniel F. Jones
13. Birthplace Pulaski Va.

MOTHER
14. Maiden Name Rose Fertitta
15. Birthplace Baltimore, Md.

16 (a) Informant: Nathaniel F. Jones
(b) Address 126 Camden Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles W. Kachauskas
(b) Address 703 McHenry Street

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1948, at 10.15a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/21/48

69731

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G69731

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hr. 5min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Dorchester Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HOWARD J. BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business unknown

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 20 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1948, at 5:50 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Kruger M.D.
Medical Examiner.

Date signed 12-11-48

G697732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G697732

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 630 W. Saratoga Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT TAYLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 28 | Months | Days | If less than one day hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 20 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 19 48 at 3:15 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bullet-wound of heart and lung.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-6-48 at 3:00 A. M.
(b) Where did injury occur? 610 Mosher Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Firearms

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12-6-48

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G697353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G697353

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES [illegible] PLOWMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation unknown

11. Industry or business

FATHER
12. Name
13. Birthplace unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 20 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 23 1948 (b) Huntington Williams, M.D.
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1948, at 2:50PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Koons M.D.
Medical Examiner
Date signed 12/11/48

VS 151

Dr Williams 3325 Frederick Rd

669734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 669734

669734

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Be

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3518 Old Frederick Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Ba ltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3518 Old Frederick Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM H. BLOECHER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Mary A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1901

8. AGE: Years	Months	Days	If less than one day
47	2	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business B&O R.R.

FATHER
12. Name Christian Bloecher
13. Birthplace Germany

MOTHER
14. Maiden Name Emma
15. Birthplace Germany

16 (a) Informant Mary Bloecher
(b) Address 3518 Old Frederick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

DEC 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1948 19 at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2' 1948 to 12/21 1948 and that I last saw him alive on 12/2' 1948.

Immediate cause of death	Duration
Cardiac Failure	7
Due to Coronary thrombosis	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Williams M.D.
Address 3325 Frederick Rd Date signed 12/23/48

VS 150

G69735 Streeter

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69735

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 13-
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Oakington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA J. STREETER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Allen L. Streeter.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1869

8. AGE: Years 79 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wilton Mercer
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine Jones.
15. Birthplace Md.

16 (a) Informant Harry L. Streeter.
(b) Address 2011 Oakington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 1948 (month) (day) (year)
(c) Cemetery or crematory Maryland Park.
Location Taylor Ave.

18 (a) Funeral director Paul C. Beaumont Jr.
(b) Address 305-7 E. Eastwood Ave.

19 (a) DEC 23 1948 (b) Curtis Bay Williamsburg, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/48 19 at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ivers M.D.
Medical Examiner.
Date signed 12/22/48

VS 151

669736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

Registered No. 669736

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 - 2

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 W. Lexington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ALICE G. PERRIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
About 84			hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Peter Perrin
13. Birthplace Maryland

MOTHER
14. Maiden Name Unobtainable
15. Birthplace

16 (a) Informant Robert J. Perrin
(b) Address 2614 N. Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Maryland.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St. Huntingtown Williams, Md

19 (a) (b)
(Date received by Registrar) Registrar

DEC 28 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1948 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1948 to Dec 22 1948 and that I last saw h alive on Dec 22 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 3 days
Due to Hypertensive Cardio Vascular Disease — 2 yrs
Due to Arteriosclerosis — 4
Due to
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W. Lafayette Date signed Dec 23 48

VS 150

Please write the cause of death clearly and legibly.

G69737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G69737
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1332 N. Washington Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1332 N. Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER JACOB ADAMS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Almira Edna (Coburn)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 16, 1889

8. AGE: Years	Months	Days	If less than one day
59	11	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Police Dep't Lieutenant
11. Industry or business Beth. Steel; Sp. Pt.

FATHER
12. Name Edward Adams
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary F. Mainster
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Almira Adams
(b) Address 1332 N. Washington Street

17 (a) Burial (b) Date thereof 12/30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 23 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH December 20 1948 6.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30, 1947, to Dec. 20, 1948, and that I last saw h im alive on Dec. 15, 1948.

	Duration
Immediate cause of death: Coronary Occlusion	10 min.
Due to: Coronary Disease	Unknown
Myocarditis	Unknown
Due to: Arteriosclerosis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philibert Antignani M. D.
Address 2942 E. Fayette St. Date signed 12/21/48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

STATHAM

131a

Registered No. G69738

G69738

Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019 Somerset
(c) Hospital or institution:

10 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Somerset
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Statham

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	W

6 (b) Name of husband or wife Crawford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25-1874

8. AGE: Years	Months	Days	If less than one day
74	10	26 27	hr. min.

9. Birthplace Prospect. Va
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Richard Woodson
13. Birthplace Va.

MOTHER
14. Maiden Name Agnes Woodson
15. Birthplace Va.

16 (a) Informant Lillian Jones
(b) Address 1019 Somerset St.

17 (a) Burial (b) Date thereof 12-25-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Prospect
Location Prospect Va.

18 (a) Funeral director Samuel W. Sullivan Jr
(b) Address 1011 N. Arlington Ave

19 (a) DEC 23 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1948, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18 1948 to 12-21 1948.
and that I last saw ~~him~~ alive on 12-21 1948.

	Duration
Immediate cause of death Uremia	1 Day
Due to Chr. Cardio-Renal Vascular Disease	3-4 yrs.
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. A. Perry M. D.
Address 1920 E. Chase Date signed 12-22-48

V S 190

669739 Seekford

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 669739

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3503 Mt Pleasant Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Mt Pleasant Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virgie Ella Seekford

3 (b) If veteran, name war

3 (c) Social Security Account No. No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Lester A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1876

8. AGE: Years	Months	Days	If less than one day
72	7	17	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name ? Cubbage
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va

16 (a) Informant Anna Catherine Mitchell
(b) Address 3503 Mt. Pleasant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 24 48 (month) (day) (year)
(c) Cemetery or crematory Balto. cem.
Location East North Ave

18 (a) Funeral director Riggel Bros
(b) Address 1800 E. Lombard St.

19 (a) DEC 23 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1948 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1945 to 12-21-48 19 ; and that I last saw her alive on 12-21-48 19 .

Immediate cause of death Arteriosclerotic Cardiovascular Disease — Duration

Due to Arteriosclerosis

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Contantinis, M. D.
Address 2316 E. Conkling St. Date signed 12-22-48

93D

669740

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

669740 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 772 Sarah Anne Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH STUBER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace (Town, county, state)

10. Usual Occupation unknown

11. Industry or business

FATHER
12. Name
13. Birthplace unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 20 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1948, at 3.01a.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward H. Rigler M.D.
Medical Examiner, MD
Date signed December 13, 1948

VS 181

G69741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G69741

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Kenwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nick Leckowsky

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Approx 75			hr. min.

9. Birthplace Russia (Town, county and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Cold Spring Nursing Home
(b) Address Cold Spring Lane

17 (a) B (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or University Medical School DEC 20 1948
Location Disposition

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 23 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948, at 5:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1948 to Nov 30 1948, and that I last saw h[illegible] alive on 11/30 1948:

Immediate cause of death: Carcinoma - Stomach — Duration: 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman R Kleiman M.D.
Address 3803 Edmondson Ave Date signed 12/7/48

VS 139

669742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

669742 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd. Streets
(c) Hospital or institution:
(D.O.A.) Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 East University Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARION JONES JARMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widow

6 (b) Name of husband ~~Joseph~~ Gilbert A. Jarman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-13-1892

8. AGE: Years	Months	Days	If less than one day
56	4	9	hr. min.

9. Birthplace probably New Jersey
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Walter Jones
13. Birthplace probably Maryland

MOTHER
14. Maiden Name Grace Clarke
15. Birthplace New Jersey

16 (a) Informant Mrs. Charlotte J. Downey (daughter)
(b) Address 3921 Rexmere Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Dec-23-48. (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue. City #1.

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1948, at 9.15a M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-22-48 at approx. 8.30 a. M.
(b) Where did injury occur? 224 E. University Hosp.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury all gas burners on but unlit

23. Signature Earl B. Royer M.D.
Medical Examiner.
Date signed December 22, 1948

G69743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G69743

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5501 Park Heights Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-19
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5501 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Joseph Margolis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1880

8. AGE: Years	Months	Days	If less than one day
68	9	7	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Real Est ate

FATHER
12. Name Hyman Margolis
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Seidman
15 Birthplace Russia

16 (a) Informant Mrs. Edith Margolis
(b) Address 5501 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12- 23- 48 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cong.
Location Southern Avenue

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Avenue

19 (a) DEC 23 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH December 22 1948 at 8,30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-2-1948 to Dec.22-1948. and that I last saw him alive on Dec-22-1948.

Immediate cause of death Pulmonary Embolus — Duration —

Due to Pulmonary Tuberculosis — Duration about 4 yrs

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Herman Seidel M. D.
Address 2404 Eutaw Pl Date signed 12/23/48

VS 150

G69744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G69744

Please answer all questions in full. Where information should be carefully supplied. The accuracy is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1202 S. Clinton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 S. Clinton St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Rehmert

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1864

8. AGE: Years 84 | Months 1 | Days 9 | If less than one day hr. 18 min. 60

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Painter
11. Industry or business Self

FATHER
12. Name Gottlieb Rehmert
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Schwab
15. Birthplace Germany

16 (a) Informant John Davis
(b) Address 1202 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 23 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donell St.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto. 31

DEC 23 1948 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH 12/21/48 19 at 1:00 M

21. I certify that death occurred on the date above stated, that I attended deceased from 12/1 19 48 to 12/20 19 48 and that I last saw h[illegible] alive on 12/20 1948.

Immediate cause of death
Coronary Thrombosis
Due to Blood Clot Obliterating Coronary Artery
Due to Chronic Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration 10 Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight L. Wade, M. D.
Address 3323 E. Balto Date signed 12/23/48

Covington Williams, M.D.

X

#22 3E

BALTIMORE CITY HEALTH DEPARTMENT

G69745 CERTIFICATE OF DEATH

56E

Registered No. G69745

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Waverly
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wayne Livesay

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-14-45

8. AGE: Years	Months	Days	If less than one day
3	1	8	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER	12. Name Waverly Livesay
	13. Birthplace Va
MOTHER	14. Maiden Name Faith Baird
	15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 1948 (month) (day) (year)
(c) Cemetery or crematory Wakefield
Location Wakefield, Va.

18 (a) Funeral director Sly Funeral Home
(b) Address Boykins, Va.

19 DEC 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22-1948, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14-1948 to 12-22-1948 and that I last saw him alive on 12-22-1948.

Immediate cause of death — Duration

Due to Hand Schuller Christian Granuloma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: 12/23/48 - not complete

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

G69746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69746

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Presstman St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Naomi Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-4-04

8. AGE: Years 44 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Luther Lewis
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Hattie —
15. Birthplace Balto. Md.

16 (a) Informant Naomi Lewis
(b) Address 1307 Presstman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Presstman St

19 DEC 23 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 21 1948 at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1948 to 12-21- 1948 and that I last saw h l m alive on 12-21- 1948

Immediate cause of death Cerebral hemorrhage — Duration 3 days

Due to Hypertension ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. C. Baker M. D.
Address 1500 Division St Date signed 12-22-48

VS 150

G69747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

LCH-105123 46B

Registered No. G69747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS RILEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/27/1872

8. AGE: Years 76 | Months 5 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elias Riley
13. Birthplace Maryland

MOTHER
14. Maiden Name Pauline Bruff
15. Birthplace Maryland

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location University Medical School DEC 22 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/48 19 . at 4:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9/46 19 to 12/13/48 19 . and that I last saw him alive on 12/13/48 19 .

	Duration
Immediate cause of death: Bronchopneumonia, bilateral	7 days
Due to: Carcinoma of the stomach	5 mos.
Due to:	
Other Conditions: Secondary anemia	5 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Stutzman M. D.
Address Balto. City Hosp. Date signed 12-21-48

V S 150

Important: Physicians: please write the causes of death clearly and legibly. The information among is carefully supplied. The

G69748 B.C. 48-2122 ✓ G69748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

158 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hos ital 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 534 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: SAMUEL DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/1948

8. AGE: Years | Months: 2 | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation unknown

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 22 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948, at 1:15 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Malnutrition

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 12/13/48

VS 151

668749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. 668749

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 613 E. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN GERALD YOGMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace U N (Town, county, and state)
10. Usual Occupation K
11. Industry or business N O

FATHER
12. Name U W
13. Birthplace N N

MOTHER
14. Maiden Name K
15. Birthplace NO W

16 (a) Informant N
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 22 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1948, at 11:01 AM

21. I certify that I took charge of the remains described above, held an Inspection and Aut thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Abdolism, acute
Pulmonary tuberculosis
Due to
over
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/15/48

VS 191

G69750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G69750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital St. Joseph's 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 157 East Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	Colored	

6 (b) Name of husband or wife Flora Ames Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1887

8. AGE: Years	Months	Days	If less than one day
61	7	16	hr. min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation Boiler man
11. Industry or business

FATHER
12. Name ERNEST TAYLOR
13. Birthplace TEXAS

MOTHER
14. Maiden Name SARAH ?
15. Birthplace TEXAS

16 (a) Informant FLORA A. TAYLOR
(b) Address 157 EAST ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-24-48 (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY
Location A.A. County, Md

18 (a) Funeral director Joseph S. Lek. Jr.
(b) Address 1306 N. Central Ave

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams Mar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1948, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 20 1948 to December 21 1948, and that I last saw h im alive on December 19 48.

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to Generalized Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury
23. Signature Ray E. Lyons Jr. M. D.
Address 18 S. Greene St Signed 12/21/48

VS 150

G69751 BALTIMORE CITY HEALTH DEPARTMENT G69751

CERTIFICATE OF DEATH

131a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 314 Madison ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 North Vincent St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Neal Owens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1880

8. AGE: Years 68 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant William Neal

(b) Address 1814 Clifton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-1948 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cem

Location Baltimore Md

18 (a) Funeral director Joseph A. Lively

(b) Address 1701 West Baltimore St

19 (a) 1948 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21 1948, at 7:24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1948, to 12-21 1948, and that I last saw him alive on 12-17 1948.

Immediate cause of death: Cardio-Vascular Renal — Hypertension — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Butler M. D.

Address 2632 East Mt. Pleasant Date signed 12/22/48

Entering for William

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

Certificate Corrected
G69752 1-7-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125 B Registered No. G64752

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY CANALE

3 (b) If veteran, name war

3 (c) Social Security Account No. 046-09-2460

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Florence C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, ~~1905~~ 1906

8. AGE: Years	Months	Days	If less than one day
42 ~~43~~	3	17	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Steel worker
11. Industry or business Baltimore Steel

FATHER
12. Name Bagigoi Canale
13. Birthplace Italy

MOTHER
14. Maiden Name Nancy Mazolia
15. Birthplace Italy

16 (a) Informant Mrs. Florence Canale
(b) Address 814 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Baltimore Md

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St Paul St.

19 (a) DEC 26 1948 (Date received by registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1948, at 4.00 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Broncho-pneumonia
Degeneration of liver.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed December 23, 1948

G697:53

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 52B

Registered No. G697:53

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Mount Royal Terrace (If rural give location) 2
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Shanetta

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-30-86

8. AGE: Years	Months	Days	If less than one day
62	-	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Madden Shanetta
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Power
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4610 Edmondson Ave

18 (a) Funeral director John O. McCabe Sons.
(b) Address 1900 Eutaw Place

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1948, at 5 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 1948 to 12-22 1948, and that I last saw him alive on 12-22 1948.

Immediate cause of death	Duration
intestinal obstruction	2 wks
Due to adhesions	
Due to carcinoma of bladder	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June 1948
Major findings of operation: Carcinoma of bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Beckmann M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 12/22/48

VS 152

X

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered 18537 (937)

469754

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Frederick Ave
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 Mallow Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosetta Fettinger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Kate Theodore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 26, 1873

8. AGE: Years 75 | Months 7 | Days 25 | If less than one day: hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER / FATHER
12. Name John Keithley
13. Birthplace Md
14. Maiden Name Susan Browne
15. Birthplace Va

16 (a) Informant Mrs. Beatrice Hamilton
(b) Address 18 Mallow Hill Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 23/48 (month) (day) (year)
(c) Cemetery or crematory Fairview Cemetery
Location Altoona, Pa.

18 (a) Funeral director Harry H. Witte
(b) Address 4106 Edmondson Ave

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/48 1948, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to 21 Dec 1948, and that I last saw her alive on 21 Dec 1948.

Immediate cause of death: Bronchopneumonia — Duration 1 wk

Due to: Arteriosclerotic cardiovascular disease — Duration 10 yrs +

Due to:

Other Conditions: Senile cystitis -

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Herbst, Jr. M.D.
Address 90 E. Preston St. Balto Date signed 22 Dec 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G697:55

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G697:55

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forest St. 26-
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5711 Bluebird Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	BLACK	Married

6 (b) Name of husband or wife Ernestine Dean Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/20/1915

8. AGE: Years	Months	Days	If less than one day
33	6	2	by min.

9. Birthplace Rock Hill So. Carolina
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Army

FATHER
12. Name Wesley Williams
13. Birthplace So. Carolina.

MOTHER
14. Maiden Name Daisy Grey
15 Birthplace Columbia, So. Carolina.

16 (a) Informant Elizabeth Cathcart
(b) Address 5711 Blue Bird Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Beanty ave

19 (a) DEC 23 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1948, at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1948 to Dec. 22 1948, and that I last saw him alive on Dec. 22 1948.

Immediate cause of death	Duration
Coronary insufficiency	
Due to Aortic insufficiency & Relative Mitral insufficiency	
Due to Bacterial endocarditis	
Other Conditions Blind left eye	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jeary W. D. Hollyes M. D.
Address Md. Pen. Hosp. Date signed 12-22-48

VS 150

6697:56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. 6697:56

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 N. Port. St.
(c) Hospital or institution:
Johns Hopkins Hospital 8-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 N. Port St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN WALKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Ella Walker

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Oct. 10-1891

8. AGE: Years	Months	Days	If less than one day
57	2	13	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name John Walker
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Eliza Camphor
15. Birthplace Balto., Md.

16 (a) Informant: Ella Walker
(b) Address 1107 N. Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calv. Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave Huntingtown Williams, Md

19 (a) DEC 23 1948 (b) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1948, at 5:15 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of liver -

Due to Pharynx

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 12/23/48

VS 151

G697:57 B.C. 765499 V G697:57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Ramsey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SUSAN E. LE BON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1942

8. AGE: Years	Months	Days	If less than one day
5	11	27 28	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Leo F. Le Bon
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elenora A. Thompson
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Leo F. Le Bon
(b) Address 917 Ramsey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/25/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location E. North Ave. & Rose St.

18 (a) Funeral director JOHN J. COHAN & SON
(b) Address 901-03 Hollins St.

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1948, at 6:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumococcic Meningitis

Due to Fracture of Base of Skull

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 24 48 ? 21/2 M.
(b) Where did injury occur? Alley of 917 Ramsey St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by truck

23. Signature Earl L. Long M.D. Medical Examiner
Date signed 12/23/48

VS 151

X

G69758

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 Registered No. G69758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1155 Washington Boulevard
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city limits, write RURAL and give town)
(d) Street No. 1151 Washington Blvd
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1888

8. AGE: Years 60 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business At Home

FATHER
12. Name Charles W. Cook
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Garman
15. Birthplace Balto., Md.

16 (a) Informant Mr. Edward Cunningham
(b) Address 1151 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/25/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Ave.

18 (a) Funeral director John J. Cowan & Son 903 Hollins St.
(b) Address

19 DEC 22 1948 (Date filed by registrar) (b) Lauriston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22/48 19 , at 5:20 P M

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home? on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 12/23/48

VS 151

X

G69759 Frebel BALTIMORE CITY HEALTH DEPARTMENT G69759

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4239 Shamrock Ave
(c) Hospital or institution: Mercy 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4239 Shamrock Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT FREBEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Rose Frebel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1888

8. AGE: Years	Months	Days	If less than one day
60	7	15	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation machinist
11. Industry or business Glen L. Martin

FATHER
12. Name Edward Frebel
13. Birthplace Germany

MOTHER
14. Maiden Name Magda Glass
15. Birthplace Germany

16 (a) Informant Mrs Rose Frebel
(b) Address 4239 Shamrock Ave

17 (a) Burial (b) Date thereof Dec 24th 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Crook
(b) Address 1701-03 N. Patterson Park

19 (a) DEC 23 1948 Huntington Williams, Asst
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1948, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1948 to Dec 20 1948, and that I last saw h[illegible] alive on Dec 20 19 48.

Immediate cause of death	Duration
Heart Failure	
Due to Hypertensive CVD	
Due to Cerebro-vascular accident ??	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Buchman M. D.
Address Mercy Date signed 12-20-48

VS 150

669760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 669760

669760

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 600 S. Chapel Gate Lane

(c) Hospital or institution: Pine Crest Sanitorium 25-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lofs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 600 Chapel Gate Lane (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Albert Knackstedt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
Male	White	Widower	Mary M Knackstedt.	years

7. Birth date of deceased (mo., day, yr.) Nov 9 1875

8. AGE: Years	Months	Days	If less than one day
73	1	13	hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business U.S. Naval Academy.

FATHER

12. Name Louis Knackstedt

13. Birthplace Germany

MOTHER

14. Maiden Name Agnes. Garbis

15. Birthplace Germany

16 (a) Informant Charles L. Knackstedt

(b) Address Market St Annapolis Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 1948 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem

Location Annapolis Md

18 (a) Funeral director Phillis Lamonaco

(b) Address 1540 Liberty Heights Ave

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1948, at 2.01 P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 19 48, to December 22 19 48, and that I last saw him alive on Dec. 21 19 48.

Immediate cause of death	Duration
CARDIAC FAILURE	24 HRS
Due to Chronic MYOCARDITIS & MYOCARDIAC Degeneration	?
Due to Generalized ARTERIO sclerosis.	?
Other Conditions Senility.	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Melvin N. Borden M. D.

Address 2030 W. Fayette St Date signed 12/22/48

VS 150

X

69701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 475

Registered No. 69701

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4701 Patterson Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Patterson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna L. Balling,

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widow

6 (b) Name of husband or wife Frank J. Balling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1882

8. AGE: Years	Months	Days	If less than one day
66	8	1	hr. min.

9. Birthplace Germany,
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business At Home

FATHER
12. Name Andrew Loeblein,
13. Birthplace Germany,

MOTHER
14. Maiden Name Margaret Engel,
15. Birthplace Germany

16 (a) Informant Mrs. F. W. Schmelz,
(b) Address 4701 Patterson Ave.

17 (a) burial (b) Date thereof 12/23/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 DEC 23 1948 (b) Lucretia Williams
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 19 48 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 48, and that I last saw her alive on 19 48

Immediate cause of death	Duration
Lymphosarcoma	
Intestinal Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation May 1948
Major findings of operation: lymphosarcoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jay Martin M. D.
Address 1201 N. Calvert St Date signed

V S 150

669762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. 669762

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Oakley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-4763

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1885

8. AGE: Years 63 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Tailor

FATHER
12. Name Jacob Miller
13. Birthplace Russia

MOTHER
14. Maiden Name Rose ?
15 Birthplace Russia

16 (a) Informant Mrs Rose Miller
(b) Address 2916 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 DEC 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/48 19 , at 5:57 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 19 , to 12/23 1948 ,
and that I last saw him alive on 12/22 1948 .

Immediate cause of death Cerebral Thrombosis — Duration 1 wk

Due to arteriosclerosis

Due to

Other Conditions Carcinoma of Esophagus

(Include pregnancy within 3 months of death)

Date of operation Aug 1947

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home or on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 2320 Sutherland Date signed 12/23/49

VS 150

830

G697663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G697663 Registered No.

Please write clearly and legibly. Use the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave.
(c) Hospital or institution:
Home for the Aged of the Methodist Ch.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 - 5
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE FRANCES MORGAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1872

8. AGE: Years	Months	Days	If less than one day
76	10	16	hr. min.

9. Birthplace Anne Arundel Co., Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Romolus Girard Morgan
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Anne Balderston
15. Birthplace Frederick, Md.

16 (a) Informant Miss Miriam O. Coates
(b) Address 2211 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory Baldwin Memorial Churchyard
Location Anna Arundel Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Tennington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1948 at 3:40a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Dec 21 1948.
and that I last saw h alive on Dec 21 1948.

Immediate cause of death Carcinoma of Breast — Duration 12 Months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davies M. D.
Address 800 W 33rd St Date signed 12-23-48

VS 150

X

669704 ✓ 669704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 64

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2722 Riggs Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 0 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2722 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARETTA LAUBER

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Frederick H. Lauber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1894

8. AGE: Years	Months	Days	If less than one day
54	10	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel A. Swoyer
13. Birthplace Penna.

MOTHER
14. Maiden Name Lettia Green
15. Birthplace Del.

16 (a) Informant Mr. Frederick H. Lauber
(b) Address 2722 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Wilmington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 19 48 at 3:10a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Dec 21 1948 and that I last saw her alive on Dec 21 1948.

	Duration
Immediate cause of death Intestinal Obstruction	1 month
Due to Carcinomatosis	1 year
Due to Carcinoma Biliary Ducts	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C J Mendelis M.D.
Address 605 N Pentalon Date signed 12/22/48

VS 180

A 67458 G69765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G697656 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. - (b) County
(c) City or town Macon - (If outside city or town limits, write RURAL and give town)
(d) Street No. 192 Rogers Ave - (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Priscilla Anne Small -

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-17-48

8. AGE: Years	Months	Days	If less than one day
—	3	6	hr. min.

9. Birthplace Ga. - (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER	12. Name Ralph Small
	13. Birthplace Ga -
MOTHER	14. Maiden Name Mary Edie
	15. Birthplace New York -

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/48 (month) (day) (year)
(c) Cemetery or crematory
Location Macon Georgia

18 (a) Funeral director H. W. Meaghan
(b) Address 805 N. Calvert St

19 (a) DEC 24 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1948, at 3 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1948 to Dec 23 1948 and that I last saw he alive on Dec. 23 1948.

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Congenital Heart	
Due to Disease -	
Other Conditions Cyanotic Spells	

(Include pregnancy within 3 months of death)

Date of operation Dec 23, 1948
Major findings of operation: See above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted]
Address JOHNS HOPKINS HOSPITAL Date Dec 23 1948

VS 150

Certificate Corrected 1-17-49 X ✓ G69766

G69766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G69766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway at Fairmount
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State (Md.) M. (b) County
(c) City or town (Baltimore) Belmar
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218-5 Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Sadie (Ver Valin Van Valey) Fritz

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: ?

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2, 1872

8. AGE: Years 76 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace (Poughkeepsie), N.Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles (Ver Valin Fritz)
13. Birthplace Poughkeepsie, N.Y.

MOTHER
14. Maiden Name Clara (Fetten) Tebbert
15. Birthplace Poughkeepsie, N.Y.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27 1948 (month) (day) (year)
(c) Cemetery or crematory Manchester
Location Poughkeepsie N.Y.

18 (a) Funeral director H. Langerfass
(b) Address 1619 E. Northern

19 (a) 1949 (Date filed by registrar) (b) Huntington White (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27/48 19 . at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19-48 19 . to 12-27-48 19 .
and that I last saw her alive on 12-27-48 19 .

	Duration
Immediate cause of death Heart Failure	
Due to Hypertensive Cardiovascular Disease &	appr. 1 yr.
Due to Nephrosclerosis Hypertensive Encephalopathy	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Mitchener M.D.
Address Church Home Hosp. Date signed 12/27/48

VS 150

G65767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G69767 67 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Calvert + 33rd Streets
(b) Street address ~~1143 W. 24th St., Balto. 11~~
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days) 47

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 11 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1143 W. 24th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs Sophia Compton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-15-1885

8. AGE: Years	Months	Days	If less than one day
63	2	7	— hr. — min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business —

FATHER
12. Name Nicholas Glass
13. Birthplace France

MOTHER
14. Maiden Name Mary Priester
15. Birthplace France

16 (a) Informant Mrs. Gertrude Jacobs
(b) Address 4316 Forest Park Ave Balto

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Mary's
Location Hampden - Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1927 St. Paul St.

DEC 24 1948 (Date rec'd by registrar) By Hunter for Hilliard M. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 1948 at 855 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1948 to 12-22 1948 and that I last saw her alive on 12-22 1948

Immediate cause of death	Duration
Cerebral vascular accident	
Due to Hypertensive cardiovascular disease	
Due to —	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Mayer Jr. M.D.
Address Union Memorial Hosp. Date signed 12-22-48

VS 150

93D

G69768

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G69768
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3710 Barrington Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Barrington Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth S. McDonald

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Thomas McDonald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16 1865

8. AGE: Years	Months	Days	If less than one day
83	11	7	hr. min.

9. Birthplace Howard Co Md
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Joshua Shipley
13. Birthplace Howard Co Md

MOTHER
14. Maiden Name Margaret Leishear
15. Birthplace Howard Co Md

16 (a) Informant R. Donald Spedden
(b) Address 3710 Barrington Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location
18 (a) Funeral director Harry A. Kunkel
(b) Address 4204 Ridgewood Ave
19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/48 19 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to Dec 23/48 19 ., and that I last saw her alive on Dec 22/48 .

Immediate cause of death: Cerebral hemorrhage
Antecedent Edema
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1 hr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address Date signed 12/24/48

VS 150

669769 ✓ 669769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida GAMMERMAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years: 56 | Months | Days | If less than one day: hr. min.

9. Birthplace: Balto (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER
12. Name: Isaac
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rose
15. Birthplace: Russia

16 (a) Informant: Alan Gammerman
(b) Address: 2808 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-48 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship
Location

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2166 Eutaw Place

19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1948 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 1948 to 12/22 1948 and that I last saw h[illegible] alive on 12/22 1948

Immediate cause of death: Cardiac Decompensation
Mitral stenosis, tricuspid valvulitis, auricular thrombus
Due to: Rheumatic Heart Disease
Due to:
Other Conditions: lung abscess, acute thrombosis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: S. Bernard Jeffries M.D.
Address: Sinai Hospital Date signed 12-23-48 M. D.

VS 150

X

G69770

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. G69770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument & Lt.
(c) Hospital or institution: Sinai 71-20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6706 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL D. BEITLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Cecelia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-5-07

8. AGE: Years	Months	Days	If less than one day
41	8	17	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Pharmacist
11. Industry or business

FATHER
12. Name Charles
13. Birthplace Poland

MOTHER
14. Maiden Name Rose
15. Birthplace Poland

16 (a) Informant Cecelia Beitler
(b) Address 6706 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-48 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Rogers Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Ontario Place

19 (a) DEC 24 1948 (Date received by Registrar) (b) Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1948, at 9:03 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-22 1948 to 12-22 1948, and that I last saw him alive on 12-22 1948.

Immediate cause of death Cerebro. vascular accident — Duration

Due to

Due to

Other Conditions Myocardial fibrosis

(Include pregnancy within 3 months of death)
Date of operation 12-22-48
Major findings of operation: increased intracranial pressure
of autopsy: same + cerebral hemorr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benj. Silverman M. D.
Address Sinai Hosp. Date signed 12-22-48

G69771

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G69771

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3109 Kenyon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3109 Kenyon Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F Camp

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie Camp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 1 1878

8. AGE: Years	Months	Days	If less than one day
70	4	21	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation Auto Mechanic
11. Industry or business

FATHER 12. Name Joseph Camp
13. Birthplace Md

MOTHER 14. Maiden Name Josephine Weedler
15. Birthplace Md

16 (a) Informant Mrs Minnie Camp
(b) Address 3109 Kenyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24/48 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 (a) DEC 24 1948 (Date rec'd by registrar) Washington Hilligoss M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1948 at 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1948, to Dec 22 1948.
and that I last saw h/M alive on Dec 19 1948.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions Parkinsonism Hernia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 3001 Shannon Drive Date signed Dec 22 48

VS 180

G69772

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131B

G69772 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Catalpha Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4703 Catalpha Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Charles E Coreswell

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-10-6786

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charlotte

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) June 1, 1891

8. AGE: Years 57 | Months 6 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Eggs Distiller

FATHER
12. Name Benj Hamilton Coreswell
13. Birthplace Balto

MOTHER
14. Maiden Name Ida Steele
15. Birthplace Va

16 (a) Informant Mrs Charlotte Coreswell
(b) Address 4703 Catalpha Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24, 48 (month) (day) (year)
(c) Cemetery or crematory Morland
Location Gayler Ave

18 (a) Funeral director L Heckrotte & Son
(b) Address 6067 Harford Rd

19 (a) DEC 24 1948 (Date rec'd by registrar) (b) ... Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21-48 19 ... at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31-47 to Dec 21-48, and that I last saw him alive on Dec 21-48

Immediate cause of death Myocarditis — Duration 2 yrs

Due to —

Due to —

Other Conditions Cirrhosis — Duration 1 yr.
Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

Autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature H. H. Hartmann M. D.
Address 1710 E 33rd St Date signed 12/23/48

93E

G69773

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G69723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 Maryland Ave
(c) Hospital or institution: 12 05
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jenning

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1886

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation D.
11. Industry or business

FATHER
12. Name James Jenning
13. Birthplace Va

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Va

16 (a) Informant Lillian King
(b) Address 1806 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Isaac L Brown Son
(b) Address 108 W Montgomery St

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1948, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1948 to Dec 22 1948, and that I last saw h[er] alive on Dec 22 1948.

Immediate cause of death	Duration
Congestive Heart Failure	Unknown
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Garland Shirell Jr M. D.
Address 902 W. Franklin Date signed 12-29-48

VS 150

G69774 ✓ G69774Y

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No.

G69774

Please write plainly; please write the causes of death clearly and legibly. Use only black ink. Do not use pencil. Do not abbreviate or use ditto marks. Be sure to answer every question.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1910 Cedric Road
(c) Hospital or institution: 15-09
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 Cedric Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry H. Wagner

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Golda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1873

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Baltimore (Town or county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER — 12. Name	Abraham
FATHER — 13. Birthplace	Russia
MOTHER — 14. Maiden Name	Jennie
MOTHER — 15. Birthplace	Austria

16 (a) Informant Golda Wagner
(b) Address 1910 Cedric Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-48 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Belair Road
18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place
19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Clinton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23- 1948, at 7:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 ✓ 19.., to 12-23 1948, and that I last saw h[illegible] alive on 12/23 1948.

Immediate cause of death: Coronary Thrombosis
Due to: Cardiac Insufficiency
Due to: Cardiac Hypertrophy
Other Conditions: Paget's Disease
(Include pregnancy within 3 months of death)

Duration
4 days
5 days
8 years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore Cooper M. D.
Address 2201 Eutaw Place Date signed 12/23/48.

VS 150

G69775 — BALTIMORE CITY HEALTH DEPARTMENT — G69775 — Registered No. 937

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 Poplar Grove St.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) About 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Poplar Grove St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME William B. DuVall

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Annie E. DuVall
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 27, 1857

8. AGE: Years	Months	Days	If less than one day
91	6	26	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation Retired B. & O. R.R.
11. Industry or business Carpenter

FATHER
12. Name Benjamin DuVall
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth (?)
15. Birthplace Md.

16 (a) Informant Mrs. Odie M. Haines (neice)
(b) Address 518 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mon Dec 27, 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore Md.

18 (a) Funeral director E. Howard Emmert
(b) Address 1400 E. Chase St. Baltimore Md.

19 (a) Dec 24 1948 (Date rec'd by registrar) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Thurs, Dec 23, 1948, at 3:20 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1948 to Dec 23 1948, and that I last saw him alive on Dec 22 1948.

Immediate cause of death: Myocardial degeneration & Insufficiency
Due to arteriosclerotic type heart disease with Cardiac hypertrophy and congestive failure
Due to Generalized arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 1 mo. 1 day. many yrs.

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Wm Michel M. D.
Address 901 Edmondson Ave. Date signed Dec 23 1948

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied. The

G69776 ✓ G69776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1310

The exact age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4215 Belmar Ave
(c) Hospital or institution: 3 k c 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 Belmar Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Italy

3 (a) FULL NAME Concetta Barbara Bonomo

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife Vincenzo Bonomo
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 2, 1877

8. AGE: Years	Months	Days	If less than one day
71	7	20	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Domestic wife
11. Industry or business At Home

FATHER 12. Name Salvatore Cimino
FATHER 13. Birthplace Italy
MOTHER 14. Maiden Name Augustina De Stephano
MOTHER 15. Birthplace Italy

16 (a) Informant Samuel Bonomo
(b) Address 4215 Belmar Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore Road
18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Greenmount Ave

19 (a) Dec 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1948 at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1947 to Dec. 22 1948 and that I last saw h[illegible] alive on Dec. 22 1948

Immediate cause of death: Chronic Myocarditis — Duration 1944
Due to: Chr. Interstitial nephritis — Duration 1944
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Samuel Bonomo
Address 1663 N. York St. Date signed 12/27/48 M.D.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G69777 — 939 — Registered No. G69777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) 15 D.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Edward E. Burke) Edward Burke

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Lucy M. Burke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1876

8. AGE: Years 72 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Brick Layer
11. Industry or business David Posner

FATHER
12. Name Joseph Burke
13. Birthplace Minn.

MOTHER
14. Maiden Name Mary Carter
15. Birthplace --

16 (a) Informant Mrs. Lucy M. Burke
(b) Address 2027 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1948, at 11:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h. z death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C-V Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12/23/48

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G697.8 ✓ 1242 Registered No. 697.8

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4-0 ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT EARL DAULBAUGH

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife Mary Daulbaugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1894

8. AGE: Years	Months	Days	If less than one day
54	3	11	hr. min.

9. Birthplace Washington, Pa.
(Town, county, and state)

10. Usual Occupation -
11. Industry or business -

FATHER
12. Name William Daulbaugh
13. Birthplace Washington, Pa.

MOTHER
14. Maiden Name Sarah Long
15. Birthplace Ridgely, W. Va.

16 (a) Informant Miss Catherine Daulbaugh
(b) Address 506 W. Fayette St.

17 (a) Burial (b) Date thereof 12/26/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 24 1948 (b) Registrar
(date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1948, at 3:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cirrhosis of liver.
Ruptured esophageal varices.
Hemorrhage into stomach.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Geo. C. Merrill M.D.
Medical Examiner.
Date signed 12/21/48

X

669779

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 669779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 A
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Sulgrave Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM ELLIS (William E. Ellis)

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Catherine Hanna Ellis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1917

8. AGE: Years	Months	Days	If less than one day
31	11	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Carr Consolidated Biscuit Co.

FATHER
12. Name Frank T. Ellis
13. Birthplace Kearney, Neb.

MOTHER
14. Maiden Name Emma N. Englar
15. Birthplace Frostburg, Md.

16 (a) Informant: Mr. Frank T. Ellis
(b) Address 100 W. University Pkwy.

17 (a) Burial (b) Date thereof 12/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 24 1948 (b) Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/48 19 at 4:45 A M

21. I certify that I took charge of the remains described above, held an Inspection Inquest and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Lauro M.D.
Medical Examiner.
Date signed 12/23/48

Huntington Williams, M.D.

G69780 ✓ G69780 80

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5606 Pimlico Rd.
(c) Hospital or institution:
~~2·19~~
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5606 Pimlico Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME W. WALLACE KEMP

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Velma D. Kemp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 10, 1881

8. AGE: Years	Months	Days	If less than one day
67	2	12	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation President
11. Industry or business C. M. Kemp Mfg. Co.

FATHER
12. Name Clarence M. Kemp
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Roby
15. Birthplace Md.

16 (a) Informant Mrs. Velma D. Kemp
(b) Address 5606 Pimlico Rd.

17 (a) Burial (b) Date thereof 12/25/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
Balto., Md.
(b) Address ~~Huntington Hotel~~

19 (a) (b) 6
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1939 to Dec 22 1948.
and that I last saw h alive on. Dec 22 1948.

Immediate cause of death
Uremia — Duration 3 days
Due to Cardio-renal disease — ?
Due to Arteriosclerosis — ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Samuel H Lieber M. D.
Address 526 Pimlico Rd. Date signed

vb 1/50

G69781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G69781 Registered No. 81

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St Balto Md.
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) yr. mo. da 1-3-9
(e) Length of stay in Baltimore (yrs., mos., or days) 13-0-7 52 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th St Balto.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin, Frances Louisa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) ~~Single, married~~, widowed, or divorced [redacted]

6 (b) Name of ~~husband or wife~~ Martin Oscar Benjamin

~~6 (c) If alive, give age~~ years

7. Birth date of deceased (mo., day, yr) May 1, 1856

8. AGE: Years 92 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Philadelphia, Penna.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Robert Meltrum Foust
13. Birthplace Unknown

MOTHER
14. Maiden Name Ann Jane Roney
15. Birthplace Philadelphia

16 (a) Informant (Mrs) Frances M. Hazard
(b) Address 700 W. 40th St Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1948, at 11:22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1947, to 12/23 1948, and that I last saw h[er] alive on 12/23 1948.

Immediate cause of death
Arteriosclerosis Obliterans
Due to Hypertensive Cardiovascular Renal Disease

Due to

Other Conditions Abscess Right Eye (Operation)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
20 years
20 years
6 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Harpurger M.D.
Address 214 Medical Arts Bldg. Date signed 12/27/48

VS 153

H 2493E. G69782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58E

Registered No. G69782 P2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17-01

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 643 N. Franklin St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME James Larry Burrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-28-39

8. AGE: Years 9 | Months 7 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James J. Burrell
13. Birthplace Va

MOTHER 14. Maiden Name Mary Jackson
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-48 (month) (day) (year)
(c) Cemetery or crematory Carpenters Mem. Park
Location Arbutus Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Brantley ave

19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Burlington Interment Co. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22-1948, at 1.48 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1948, to 12-22 1948, and that I last saw h[illegible] alive on 12-22 1948.

Immediate cause of death Heart failure — Duration

Due to Probable Rheumatic fever.

Due to HEMOPTYSIS

Other Conditions Hemoptysis.

(Include pregnancy within 3 months of death)

Date of operation not performed

Major findings of operation:

of autopsy: not completed.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

VS 150

G669783 BALTIMORE CITY HEALTH DEPARTMENT G669783 83
Registered No.

CERTIFICATE OF DEATH

93c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4302 Springdale Ave
(c) Hospital or institution:
428 W

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4813 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Laura S. Wagner.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17 1863.

8. AGE: Years 85 | Months 4 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Carl August Wagner.

13. Birthplace Germany

14. Maiden Name Pamelia Master.

15. Birthplace

16 (a) Informant C. M. August.

(b) Address 4813 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22/48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville Md

18 (a) Funeral director E. Willis Langrall

(b) Address 4510 Liberty Heights Ave

19 (a) DEC 23 1948 (Date rec'd by Registrar) (b) Director Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1948 at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1940, to Dec 22 1948, and that I last saw h[illegible] alive on Dec. 22 1948

Immediate cause of death
1) Arteriosclerosis
Cardio-Vascular Disease

Due to

Due to Generalized Arteriosclerosis.

Other Conditions: Chronic Infections Arthritis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration
10 yrs.?
5 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.

Address 4108 Liberty Hts. Date signed 12/23/48

Please answer all questions. Information should be carefully supplied. The accuracy is especially important. Physicians: please write the causes of death clearly and legibly.

G69784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G69784 84

Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1115 Etting Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17-0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harrison Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary E. Mitchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 14, 1893

8. AGE: Years	Months	Days	If less than one day
55	6	8	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jeff Mitchell
13. Birthplace Va.

MOTHER
14. Maiden Name Susie ?
15. Birthplace Va.

16 (a) Informant Mrs. Mary E. Mitchell
(b) Address 1115 Etting St.

17 (a) Burial (b) Date thereof 12-27-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) DEC 24 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 22, 1948, at 3:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21/48, to 19..., and that I last saw [illegible] alive on 12/21/1947.

Immediate cause of death
Due to (b) Pneumonia
Due to (c)
Other conditions Hemiplegia, right side
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Wentzel M.D.
Address 724 N. Carey St. Date signed 12/23/1947

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669785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

669785 85

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 21-02
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) ? 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1238 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ARCHIE COLUMBUS TREAKLE

3 (b) If veteran, name war WW I

3 (c) Social Security Account No. --

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Laura Kellum Treakle

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) March 7, 1899

8. AGE: Years 49 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business CG yard- Curtis Bay, Md.

FATHER
12. Name Wm. Treakle
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Gage
15. Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 12/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Natl Cem
Location 5501 Frederick Ave

18 (a) Funeral director John J. Coogan & Son
(b) Address 901-03 Hollins St.

19 (a) DEC 24 1948 (b) Washington Heights, Md. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1948, at 3:34 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1948 to Dec. 24 1948, and that I last saw h im alive on Dec. 24 1948.

Immediate cause of death Carcinoma, type indetermined, left lung with metastasis to liver — Duration: Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 12/24/48

VS 180

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The entry item of information should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

669786 46E Registered No. G69786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3022 Gwynns Falls Parkway
(c) Hospital or institution: 15-07
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Gwynns Falls Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elias Grant Neiswender

3 (b) If veteran, name war ----
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Laura H. Neiswender
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1868

8. AGE: Years	Months	Days	If less than one day
80	7	13	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Ephriam Neiswender
13. Birthplace Pa.

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. George W. Kelley
(b) Address 3022 Gwynns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 2.10

20. DATE OF DEATH December 23, 1948, at p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25 1940, to Dec. 23 1948, and that I last saw him alive on Dec. 23 1948.

Immediate cause of death: Carcinoma of colon — Duration: 9 months
Due to:
Due to:
Other Conditions: Arteriosclerosis - Heart Disease - Mitral Stenosis — 10 yrs.
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl F. Chambers M. D.
Address 4108 Liberty Hts. Date signed 12/24/48

VS 150

G69787

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1210

Registered No. G69787

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-07
(e) Length of stay in Baltimore (yrs., mos., or days) 37

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Milton Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA FITCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 6, 1896

8. AGE: Years: 52 | Months: 6 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Nelson Co. Va
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

MOTHER / FATHER

12. Name: Unknown

13. Birthplace

MOTHER

14. Maiden Name: Unknown

15. Birthplace

16 (a) Informant: John Fitch

(b) Address: 533 Milton Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 27, 1948 (month) (day) (year)

(c) Cemetery or crematory: Mt. Auburn

Location: Baltimore, Md.

18 (a) Funeral director: Wm. George Sr. Stallone

(b) Address: 1631 Druid Hill Ave

19 (a) Dec 24 1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 December 1948, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 21 Dec. 1948, to 23 Dec. 1948, and that I last saw h alive on 23 Dec. 1948.

Immediate cause of death	Duration
Cardiac decompensation	5 days
Due to Hypertensive Cardio-Vascular Renal disease	15 mos.
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Cox M. D.

Address 515 Madison Ave Date signed 12-27-48

VS 153

G69788

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1310

G69788 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1847 Druid Hill Ave.
(c) Hospital or institution: 14-0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1847 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Cordelia Shields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1896

8. AGE: Years 62 | Months 4 | Days 22 | If less than one day, hr. min. 1886

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Jennie Butler
15. Birthplace Maryland

16 (a) Informant Mrs. Richard Shields
(b) Address 1847 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Harland
(b) Address 1631 Argyle Ave

19 (a) DEC 24 1945 (b)
(Date rec'd by registrar) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1945, at 1 57/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20- 1945, to 12-23- 1945, and that I last saw h alive on 12-23- 1945.

Immediate cause of death: Pulmonary edema — Duration: 24 hrs.

Due to: Cardiac decompensation — 48 hrs.

Due to: Hypertensive cardiovascular disease & Diabetes — 1 mo.

Other Conditions: Arteriosclerosis — Age
Cerebral thrombosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James P. Pilson M. D.
Address 5 E. Mosher St. Date signed 12-27-45

VS 150

G69789 BALTIMORE CITY HEALTH DEPARTMENT G69789
CERTIFICATE OF DEATH
Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 Brant St.
(c) Hospital or institution: 9-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Brant St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cora Emolia Smallwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 24, 1888

8. AGE: Years 60 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ? Thomas

13. Birthplace Upper Marlboro, Md.

MOTHER 14. Maiden Name Elizabeth Simmons

15. Birthplace Maryland

16 (a) Informant: Miss Ruth Smallwood

(b) Address 1138 Low St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mem. Pk. Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Laura A. Holland

(b) Address 1601 Druid Hill Ave.

19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Arthur Tom Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1948, at 5a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1948, to Dec 23 1948, and that I last saw h alive on 19

Immediate cause of death: Cerebral Hemorrhage — Duration 3 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theo. A. Johnson M. D.

Address 2329 Guilford Ave. Date signed Dec 29 1948.

VS 153

G69790 ✓ G69730 90

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4527 Arabia Ave
(c) Hospital or institution: 270 -
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4527 Arabia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph Bily Jr

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Albina
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Nov 14 1882

8. AGE: Years	Months	Days	If less than one day
66	1	9	hr. min.

9. Birthplace Bratislava Bohemia
(Town, county, and state)
10. Usual Occupation Meteorologist
11. Industry or business

FATHER
12. Name Joseph Bily
13. Birthplace Bohemia

MOTHER
14. Maiden Name Mary Stulik
15. Birthplace Bohemia

16 (a) Informant Albina Bily
(b) Address 4527 Arabia Ave

17 (a) BURIAL (b) Date thereof DEC 27 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK HILL
Location HORNERS LANE
18 (a) Funeral director DIPPEL BROTHERS
(b) Address 1900 E LOMBARD ST.
19 DEC 24 1948 (b) Wilhelmina M. Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1948 at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 1947 to Dec. 23 1948 and that I last saw him alive on Dec. 21 1948.

Immediate cause of death	Duration
Myocarditis	years
Due to Hypertension	years
Due to Arteriosclerosis	years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Henry L. Hamman M. D.
Address 20 E. Preston St. Date signed 12/24/48

VS 150

Dr. Grott G69791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3203 Rosalie Avenue
(c) Hospital or institution: 27-05
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Rosalie Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Medard Voelker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emilie Voelker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 18, 1867

8. AGE: Years	Months	Days	If less than one day
81	3	5	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Voelker
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Marie ?
15. Birthplace Germany

16 (a) Informant Mrs. Emilie Voelker
(b) Address 3203 Rosalie Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 DEC 24 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23rd 1948, at 1 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6/48 to 12/23/48.
and that I last saw h alive on 12/22/48

Immediate cause of death: Cerebral hemorrhage — Duration: 5 days
Due to: Hypertensive CVD — Duration: ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold A. Grott M. D.
Address 5100 Harford Rd. Date signed 12/24/48

VS 150

Keep entry neat, important. Physicians: please write the causes of death clearly and legibly.

Dr. Golley G69792 BALTIMORE CITY HEALTH DEPARTMENT ✓ G69792 9-2
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2800 Goodwood Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d.b.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Goodwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Robinson Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Grover C. Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 14, 1891

8. AGE: Years	Months	Days	If less than one day
57	9	9	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Wright Robinson
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Eaton
15. Birthplace ?

16 (a) Informant Mr. Grover C. Moore
(b) Address 2800 Goodwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-48 (month) (day) (year)
(c) Cemetery or crematory Templeville Cem.
Location Templeville Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Wm. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23rd 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to 12/23 1948
and that I last saw h alive on 12/23 1948.

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Golley M. D.
Address 5703 Harford Rd Date signed 12/24/48

VS 199

Please write the causes of death clearly and legibly. Any important supplementary information should be added.

G69793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

G69793 93

Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 7-05
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 McDonough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENE HARDY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1930

8. AGE: Years	Months	Days	If less than one day
18	6	12	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Willie Hardy
13. Birthplace Lunenburg Co. Va.

MOTHER
14. Maiden Name Ruby Laws
15. Birthplace Md.

16 (a) Informant: Willie Hardy
(b) Address 813 McDonough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. County Md

18 (a) Funeral director Mrs. Robt. A. Elbert Dept.
(b) Address 1129 N. Caroline St

19 (a) Dec 24 1948 (Date filed by registrar) (b) Clinton Williams, M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1948 at 11:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shot wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 21/48 10:25 P.M.
(b) Where did injury occur Middle of 900 block McDonogh St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature Emil L. Pongs M.D.
Medical Examiner.
Date signed 12/23/48

G69794

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G69794

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 Herbert Street
(c) Hospital or institution: 15-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Herbert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL F. BRIM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Clara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1901

8. AGE: Years	Months	Days	If less than one day
47	2	17	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Brim
13. Birthplace Anne Arundel County, Maryland

MOTHER
14. Maiden Name Adele Bradley
15. Birthplace Baltimore, Maryland

16 (a) Informant Clara Brim
(b) Address 1925 Herbert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Anne Arundel County, Maryland

18 (a) Funeral director MRS. ROBT. A. ELLIOTT & DGT.
(b) Address 1129 N. Caroline Street

19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1948, at M

21. I certify that I took charge of the remains described above, held an Inspection and Inq thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/30/48

VS 151

11Ft 3E G69795

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G69795 95 — 114E — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-C
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 836 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbra Jean Raye

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-7-39

8. AGE: Years	Months	Days	If less than one day
9	1	15	hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James L Barnes
13. Birthplace

MOTHER 14. Maiden Name Ruth Raye
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 23/48 (month) (day) (year)

(c) Cemetery or crematory
Location Kentucky

18 (a) Funeral director Mrs. Pott & Elliott Dept
(b) Address 1129 N. Carlton St

19 (a) DEC 24 1948 Date received by registrar (b) Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 1948, at 1825 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21 19 , to 12-22 1948, and that I last saw h er alive on 12-22 1948.

Immediate cause of death	Duration
Anoxia	
Due to Pneumothorax	
Due to Congenital cystic disease of the lung	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P Hanson M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

G69796

BALTIMORE CITY HEALTH DEPARTMENT G69796 Registered No. [illegible]

CERTIFICATE OF DEATH 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624 Harlem ave
(c) Hospital or institution: 16 " "
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) over 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Harlem ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Annie Sanders

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	colored	widowed

6 (b) Name of husband or wife Isiah Sanders
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) April 29 - 1867

8. AGE:	Years	Months	Days	If less than one day
	81	7	24	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business Cookhouse

FATHER
12. Name Robert Dallis
13. Birthplace Maryland

MOTHER
14. Maiden Name Lavan Johnson
15. Birthplace Md

16 (a) Informant Robert Sanders
(b) Address 1624 Harlem ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Pressstman ST

19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Huntington Ave Cemetery Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23 1948, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-45 1948, to 12-23 1948, and that I last saw her alive on 12-23 1948.

Immediate cause of death Carcinoma of intestines — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 12-24-48

VS 150

G69797

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52a

Registered No. G69797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 19 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford Darlington
(c) City or town Harford Co Darlington
(If outside city or town limits, write RURAL and give town)
(d) Street No. R 7 D 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Gerhard Lurman

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Amelia
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr) 7-24-90

8. AGE: Years 58 | Months 4 | Days 29 | If less than one day: hr. min.

9. Birthplace Md (town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Theodore G Lurman
13. Birthplace Md

MOTHER
14. Maiden Name Jannie A Pilchman
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27 1948 (month) (day) (year)
(c) Cemetery or crematory Darlington
Location Darlington Harford Co Md

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address 4905 York Rd #12

19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 193

MEDICAL CERTIFICATION

40p

20. DATE OF DEATH Dec. 23 1948, at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1948, to 12/23 1948, and that I last saw h alive on 12/23 1948.

Immediate cause of death: squamous cell carcinoma of kidney — Duration: 2 yrs
Due to
Due to
Other Conditions carcinomatosis

(Include pregnancy within 3 months of death)
Date of operation 1946
Major findings of operation: Some
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L R Beckmann M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 12/23/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G69798 ✓ 93 — Registered No. G69798 91

G69798

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 S Luzerne Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 S. Luzerne Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Miedusiewski - (Miedzuszewski).

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eleanora Pondo

6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): February 2, 1885

8. AGE: Years: 61 (63) | Months: 10 | Days: 2/(22) | If less than one day: hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: Merchant

11. Industry or business

FATHER
12. Name: Joseph ?
13. Birthplace: Poland

MOTHER
14. Maiden Name: Caroline ?
15. Birthplace: Poland

16 (a) Informant: Eleanora Miedusiewski
(b) Address: 625 S. Luzerne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/27/48 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart Cemetery
Location: Dundalk Ave.

18 (a) Funeral director: Lilly & Zeiler, Inc.
(b) Address: 403 S. Wolfe St.

19 (c) DEC 24 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23, 1948, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1946 to Dec. 23 1948, and that I last saw h[illegible] alive on Dec 23, 1948.

Immediate cause of death: Chronic Myocarditis — Duration: [illegible]

Due to: Arteriosclerotic Cardiovascular Disease — Duration: [illegible]

Due to: — Duration:

Other Conditions: Bronchopneumonia — Duration: 1 day

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Samuel A. Brook, M. D.
Address: 1331 E. North Ave. Date signed: 12-24-48

VS 190

X

B.C. 48-2710

G69799

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G69799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Payson t Fayette So
(c) Hospital or institution: Bon Secour Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15-66

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Braddish Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Gerard Joseph Sewell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22, 1948

8. AGE: Years	Months	Days	If less than one day
—	—	—	22 hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name MARIAN SEWELL JR.
13. Birthplace ROCK HALL - Md.

MOTHER
14. Maiden Name LORETTA LEWIS
15. Birthplace WILKES BARRE - PA

16 (a) Informant MARIAN Sewell - JR.
(b) Address 1913 BRADDISH AVE

17 (a) Burial (b) Date thereof 12-24-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location FREDERICK AVE

18 (a) Funeral director THOS. J. KENNY - INC
(b) Address 1600 HOLLINS ST

19 (a) Dec 24 1948 (b) Huntington for Williamsport, Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1948, at 3:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1948 to Dec. 23 1948 and that I last saw him alive on Dec. 22 1948.

Immediate cause of death Prematurity - 6 months — Duration

Due to Cardiac failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D Schuhler
Address Bon Secour Hosp Date signed 12/23/48 M. D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

48434 669800 669800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Midway — (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 E Washington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Lenore

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah B. Lenore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-13-14

8. AGE: Years 31 | Months 11 | Days 10 | If less than one day: hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Miner

11. Industry or business

FATHER
12. Name Frank Lenore.
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Lpada.
15. Birthplace Pa.

16 (a) Informant Rosario
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/24/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Midway
Location Pennsylvania

18 (a) Funeral director William J. Tichnor & Sons
(b) Address North & Pa. Aves. Balto. Md

19 (a) DEC 24 1948 (Date rec'd by registrar) (b) Huntington Hollingsworth Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1948, at 11 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17 1948 to Dec 23 1948 and that I last saw him alive on Dec. 23 1948

Immediate cause of death: Operative Hemorrhage — Duration

Due to: Mediastinal Semord — 6 mos

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 12-23-48

Major findings of operation: Mediastinal Semord

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Handelsman M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 12-23-48

Please write the causes of death clearly and legibly.

G69801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

G69801 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2706 Dillon st
(c) Hospital or institution: 1-04

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Dillon (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Ratynski

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Magdalena Ratynska
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) aug 30 1888

8. AGE: Years	Months	Days	If less than one day
60	3	24	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Tavern
11. Industry or business Own Business

FATHER
12. Name John Ratynski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Magdalena Ratynska
(b) Address 2706 Dillon st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28 48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem
Location Dundalk Ave

18 (a) Funeral director Stephen J. Fratkowski
(b) Address 1900 E Kenwood ave

19 (a) DEC 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1948 at 1.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1948, to Dec 24 1948, and that I last saw h alive on Dec 24 1948.

Immediate cause of death
Cerebral Embolism
Occluding thrombus of
Due to abdominal aorta

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: None

Duration
Dec 11 1948
Dec 24 1948

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Schumacher M. D.
Address 842 S. Eastern Date signed 12-27-48

VS 153

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 669802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3013 Elliott st.
(c) Hospital or institution: 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Elliott st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry ~~Stichel~~ Stichel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Frances Stichel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1902

8. AGE: Years	Months	Days	If less than one day
46	5	15	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Street metal worker.

11. Industry or business J.A. Harding

FATHER
12. Name William Stichel
13. Birthplace Balto Md

MOTHER
14. Maiden Name unknown
15. Birthplace Balto Md.

16 (a) Informant Mrs. Frances Stichel
(b) Address 3013 Elliott st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel Cem
Location Mt. Carmel road

18 (a) Funeral director Stephen J. Fiakowski
(b) Address 1000 S. Kenwood Ave

19 (a) DEC 25 1948 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24/48 19 , at 4:55 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D. Medical Examiner.
Date signed 12/24/48

VS 151

G69803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G69803 63

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 Newington Ave
(c) Hospital or institution:
13-21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Newington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William. Wolfsheimer,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Rena Wolfsheimer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28 1881

8. AGE: Years	Months	Days	If less than one day
67	7	27	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Tax Consultant

11. Industry or business

FATHER
12. Name Nathan Wolfsheimer
13. Birthplace Germany

MOTHER
14. Maiden Name Babette Scholeef
15. Birthplace Baltimore Md

16 (a) Informant Mrs Morris Schaffer
(b) Address 710 Newington Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)

(c) Cemetery or crematory Ohev Sholom Cem
Location Oldorchester St

18 (a) Funeral director J. Ahrens Co
(b) Address 243 W Baltimore St

DEC 26 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1948, at 6.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1948 to Dec 25 1948.
I last saw him alive on Dec 20 1948.

Immediate cause of death

	Duration
Coronary thrombosis	instant
Due to Cardiac failure & pulmonary edema	2 or 3 weeks
Due to	
Other Conditions Pregnancy of	

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury

23. Signature Fred H. Kolman MD
M. D.
Address 3700 Park Heights Ave Date signed Dec 25 48

VS 150

#24 40 G69804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

G69804 Registered No. 0 0

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A. Co.
(c) City or town Eastport (If outside city or town limits, write RURAL and give town)
(d) Street No. 946 Creek Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Milton Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-22-48

8. AGE: Years 0 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Woods
13. Birthplace Md

MOTHER 14. Maiden Name Bessie Nathey
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff
Location Annapolis Md

18 (a) Funeral director B. F. Hopkins & Son
(b) Address Annapolis Md.

DEC 28 1948

19 (a) (Date rec'd by registrar) (b) Lington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24 1948, at 8:03 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5 1948, to 12-24 1948, and that I last saw him alive on 12-24 1948.

Immediate cause of death

Due to Tbc meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. C. Carey M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 12-24-48

G69805

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G69805

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 8-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3422 Elmora Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Ralph Moffett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Dorothy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28. 1894

8. AGE: Years	Months	Days	If less than one day
54	0	26	hr. min.

9. Birthplace Frederick. Md
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Charley A. Moffett
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs M. McGinnis
(b) Address 2709 Lynnbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Frederick Md

18 (a) Funeral director M. R. Etchison & Son
(b) Address Frederick Md

DEC 26 1948
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24 1948, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Heart Disease

Due to

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 12-25-48

VS 151

G69806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G69806 Registered No. 06

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway at Fairmount
(c) Hospital or institution: Church Home & Hospital 20-07
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4h. 20m.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 W. Fayette (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Warren (WARNER)

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Eva S. Warren
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1878

8. AGE: Years	Months	Days	If less than one day
70	8	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Metal Worker
11. Industry or business

FATHER
12. Name William H. Warren
13. Birthplace England

MOTHER
14. Maiden Name Anne Pickett
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.

DEC 28 1948

19 (a) (Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1948, at 5:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 1948, to 12-24 5:20 PM 1948, and that I last saw him alive on 12-24 1948.

Immediate cause of death Ventricular Fibrillation? Rupture of Ventricle — Duration: instantaneous.
Due to Myocardial Infarction } 6 days
Due to Coronary Thrombosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Mitchener Jr. M. D.
Address Church Home Hospital Date signed 12-24-48

VS 193

J. Mitchener Jr. M.D.

669807

BALTIMORE CITY HEALTH DEPARTMENT ✓ 669807

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 N. Fulton Ave
(c) Hospital or institution: 19-02
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gaspare La Fata

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Marie La Fata
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 1888

8. AGE: Years	Months	Days	If less than one day
60	6	18	hr. min.

9. Birthplace Marsala Trapani Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Pietro La Fata
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Sata
15. Birthplace Italy

16 (a) Informant Marie La Fata (Wife)
(b) Address 121 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27/48 (month) (day) (year)
(c) Cemetery ~~Lorraine~~ Holy Redeemer Cemetry
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 322 S. High St.

19 (a) DEC 26 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1948, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1947 to Dec 23 1948, and that I last saw h~~im~~ alive on Dec 23 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions Cerebral Hemorrhage 1947	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1724 W Lombard Date signed 12/26/48

VS 188

G69808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G69808 08 Registered No.

Please write plainly and fill the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1419 Laurens Street
(c) Hospital or institution: 16 or

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 Laurens Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES W. JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs Roberta Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 16, 1876

8. AGE: Years 72 | Months 2 | Days 7 | If less than one day: hr. min.

9. Birthplace: Gloster, Virginia (Town, county, and state)

10. Usual Occupation: Minister

11. Industry or business

FATHER
12. Name: Phillip Johnson
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Sarah Talliferro
15. Birthplace: Virginia

16 (a) Informant: Elaine Harvey
(b) Address: 1202 Druid Hill Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/26/48 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem Pk
Location: Arbutus, Md

18 (a) Funeral director: CHARLE R. LAW
(b) Address: 802 Madison Avenue--l

DEC 28 1948

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23 1948, at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1948 to 12-23 1948, and that I last saw h/s alive on 12-22 1948.

	Duration
Immediate cause of death: Congestive Heart Failure	2 hrs.
Due to: Arteriosclerotic Heart Disease	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Clifford O. Swanson M. D.
Address: 2309 Druid Hill Ave Date signed: 12-24-48

VS 150

G69803 ✓ G69803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4212 Parkmount Ave
(c) Hospital or institution: 9-05

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 E 33rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Branch

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Paul Branch

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 8 1875

8. AGE: Years 73 | Months 9 | Days 16 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Nathael Walker
13. Birthplace: England

MOTHER
14. Maiden Name: Laula Freeman
15. Birthplace: Maryland

16 (a) Informant: Paul F Branch
(b) Address: 1705 E 30th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-27-48 (month) (day) (year)

(c) Cemetery or crematory: Baltimore Co
Location: E Baltimore Co

18 (a) Funeral director: John C Mahan
(b) Address: 3000 E Baltimore St

19 (a) DEC 26 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: DEC. 24 1948, at 7:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1948 to DEC. 24 1948 and that I last saw h[illegible] alive on Dec. 23 1948.

Immediate cause of death: CEREBRAL THROMBOSIS WITH HEMIPLEGIA (LEFT) — Duration: 7 Weeks

Due to: (a) ARTERIAL HYPERTENSION — 15 Years +
(b) CEREBRAL ARTERIOSCLEROSIS —

Due to:

Other Conditions: MYOCARDIAL DEGENERATION; SENILITY. — 1 Yr. +
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: John W Mahan M.D.
Address: 6331 Belair Rd (6) Date signed 12/24/48

VS 150

83B

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69810 ✓ G69810

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3304 Fleet St
(c) Hospital or institution:
wb 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 Fleet St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas A. Gardner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Margaret T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16, 1897

8. AGE: Years	Months	Days	If less than one day
51	4	7	hr. min.

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation Asst. Chemist
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name John Gardner
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Cryan
15. Birthplace Ireland

16 (a) Informant Margaret T. Gardner
(b) Address 3304 Fleet St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Balt. St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 19 48, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 19 47 to Dec 23 19 48 and that I last saw him alive on Dec 23 19 48;

Immediate cause of death — **Duration**

Acute Cardiac Failure.
Due to Coronary Artery occlusion
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. A. Flannigan M. D.
Address 3503 Fait Ave Date signed 12-23-48

VS 150

X

G69811

A67361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159E

Registered No. G69811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County
(c) City or town Belevernon, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 Broad, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sandra Scaccia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-7-48

8. AGE: Years | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel Scaccia
13. Birthplace Pa.

MOTHER 14. Maiden Name Elizabeth Patterson
15. Birthplace Pa.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 26, 1948 (month) (day) (year)

(c) Cemetery or crematory
Location Bellevernon, PA.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & penna. Aves

19 (a) (Date rec'd by registrar) DEC 27 1948 (b) Huntington Williams, M.D.
S. No.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1948 at 11 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15- 1948 to 12-24 1948 and that I last saw her alive on 12-24 1948.

Immediate cause of death Cerebral haemorrhage

Due to

Due to Cong. Heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Furey M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 12-25-48

X

669812

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 669812

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8123 Cornwald Road
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County [illegible]
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8123 Cornwald Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Joshua Wallace Harrison

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs. Anna Harrison
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1902

8. AGE: Years	Months	Days	If less than one day
46	4	24	15 hr. ____ min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Benjamin Harrison
13. Birthplace Maryland

MOTHER
14. Maiden Name Drew Harrison
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery or crematory Stephenson M. E.
Location Stephenson, Md.

18 (a) Funeral director J. Fred Mogle
(b) Address Stephenson Md.

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1948, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24-48 a.m. 19____, to 12-26 4:00 P.M. 1948 and that I last saw him alive on Dec 26 1948.

Immediate cause of death: Heart Failure
Myocardial Infarction
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration: 3 days.

Date of operation None
Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Whitehead Jr. M. D.
Address Church Home Hospital

VS 150

#74869 G69813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 136

Registered No. G69813

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County K
(c) City or town Chestertown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Lively

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-25-96

8. AGE: Years	Months	Days	If less than one day
52	8	1	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name See Dent.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Harley
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12/29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Chestertown

18 (a) Funeral director Legis M. Dutton
(b) Address Chestertown, Md.

19 DEC 27 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1948 at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1948 to Dec 26 1948 and that I last saw her alive on Dec 26 1948

Immediate cause of death Resp. failure — Duration

Due to Meningitis.

Due to Tuberculosis

Other Conditions Tuberculosis of lungs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan Calkins. M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

VS 153

X

G69814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G69814 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911 COLE ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 9.0

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 COLE ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY M McGOWAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-3494

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of ~~husband or~~ wife WILLOW M (SHAW)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 24, 1883

8. AGE: Years	Months	Days	If less than one day
65	11	0	hr. min.

9. Birthplace PENNA (Town, county, and state)
10. Usual Occupation STOCK KEEPER
11. Industry or business BETHLEHEM STEEL

FATHER
12. Name ISSAC McGOWAN
13. Birthplace PA

MOTHER
14. Maiden Name MELISA WATSON
15. Birthplace PA

16 (a) Informant MRS HARRY M McGOWAN
(b) Address 1911 COLE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC, 29 '48 (month) (day) (year)
(c) Cemetery or crematory MT OLIVET
Location FREDERICK AVE

18 (a) Funeral director Harry A Gitchell
(b) Address 4109 Edmondson Ave

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Washington Wilkens, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 24 1948, at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1948 to 12/24/48 1948 and that I last saw him alive on 12/24/48 1948.

Immediate cause of death	Duration
Coronary insufficiency	3 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 1130 Wilkens Ave Date signed 12/27/48

VS 150

M. D. P 1259-9

G69815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

94B

Registered No. G69815

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3157 Leeds St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Anna Marie Bowen

(a) Residence: No. 3157 Leeds St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of late George W

6. DATE OF BIRTH (month, day, year) Aug. 25, 1948

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	3	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore

FATHER

13. NAME Eugene Muth

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT (Address) Mrs Gertie Pierson 236 W. Patterson Pk. Ave

18. BURIAL, CREMATION, OR REMOVAL Place Loudon Park Date Dec. 27 48

19. UNDERTAKER (Address) Harry A Witzke 4161 Edmondson ave

20. FILED DEC 27 1948 Washington Williams M.D.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec. 23 48

22. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1948, to Dec 23, 1948

I last saw her alive on Dec 22, 1948 Death is said to have occurred on the date stated above, at 7 a m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Angina Pectoris	June 48
Other contributory causes of importance: Arteriosclerosis	37 yrs

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) A. C. Samuels M. D.

(Address) 4509 Liberty Hgts

X

669816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669816

A1611690 1579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 S. Oldham, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alton Absher Jr. (GEORGE ALTON L. ABSHER)

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Sngl

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-29-48

8. AGE: Years | Months: 10 | Days: 27 | If less than one day: hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER — 12. Name Alton Absher

FATHER — 13. Birthplace N. C.

MOTHER — 14. Maiden Name Jean Lambos

MOTHER — 15. Birthplace Md.

16 (a) Informant records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/49 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore, Md.

18 (a) Funeral director Wilson Sons & Lee

(b) Address 1219 E. Cold St.

19 (a) DEC 27 1948 (Date rec'd by registrar) Herrington Williams, M.D.

MEDICAL CERTIFICATION 4-45

20. DATE OF DEATH December 26 1948 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-11- 1948 to 12-26-1948 and that I last saw him alive on 12-26-1948

Immediate cause of death: Asphyxia

Due to: atelectasis, and pneumonia

Due to:

Other Conditions: Cong. megacolon

(Include pregnancy within 3 months of death)

Date of operation 7 May 1948

Major findings of operation: Cong. megacolon

of autopsy: atelectasis, pneumonia

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Barney M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 12-29-48

VS 153

G69817

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G69817 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-01
(e) Length of stay in Baltimore (yrs., mos., or days) 14-01

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Euatw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA KALVELAGE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry Kalvelage

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25th 1867

8. AGE: Years 81 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name (Unknown) Kalvelage
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Raymond Mooney
(b) Address 1017 Somerset St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Peters
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) DEC 27 1948 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24, 1948, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocarditis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Mekull M.D.
Medical Examiner.

Date signed 12-24-48

VS 181

G69818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 646 Bartlett Ave.
(c) Hospital or institution: 9-08
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 646 Bartlett Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD S. HARRISON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nina E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1873

8. AGE: Years	Months	Days	If less than one day
75	6	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Paperhanger, retired
11. Industry or business

FATHER
12. Name Joseph A. Harrison
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace Md

16 (a) Informant John W. Harrison
(b) Address 610 Ba rtlett Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 DEC 27 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1948 19 , at 11:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 19 48 to Dec. 23 1948, and that I last saw h alive on Dec. 22 19 48

Immediate cause of death	Duration
Myocardial Insufficiency	4 days
Due to Myocarditis	6 mos
Due to Chronic Nephritis	1 Year
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. White M. D.
Address 3809 Gwynn Oak Ave. Date signed 12/24/48

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69819

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

Registered No. G69819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 328 N. Paca St.
(c) Hospital or institution: 4-0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 328 N. Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LINA J. CONN

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	Female	White	Widow

6 (b) Name of husband or wife Thornton W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1878

8. AGE: Years	Months	Days	If less than one day
70	5	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George W. Hargest
13. Birthplace Md

MOTHER
14. Maiden Name Ella Faust
15. Birthplace Pa

16 (a) Informant Pearl Conn
(b) Address 328 N. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Funeral Director Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1948 19 , at 7:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to Dec 23 1948, and that I last saw her alive on Dec 23 1948.

Immediate cause of death valvular heart disease — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Patterman M. D.
Address 2324 Reisterstown Rd Date signed 12/24/48

VS 150

X

G69820 — BALTIMORE CITY HEALTH DEPARTMENT — G69820

CERTIFICATE OF DEATH 93E

Registered No.

Please type or print plainly. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2814 Riggs Ave
(c) Hospital or institution: 16-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Riggs Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura E. Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife Robert C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1861

8. AGE: Years	Months	Days	If less than one day
87	1	1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Eagles
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Gates
15. Birthplace Maryland

16 (a) Informant R. Ellsworth Jones
(b) Address 224 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27 1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1948, at 2.54 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1948, to Dec 23 1948, and that I last saw her alive on Dec 23 1948.

Immediate cause of death	Duration
Cardiac Asthenia	
Due to C.P.C. Lungs.	2 months
C.P.C. Kidneys.	2 mos
Due to Intracranial Metastasis	1 week
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr Ellsworth Jones M. D.
Address 1202 St Paul St Date signed 12/27/48

VS 150

669821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

669821 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland DOA
(b) Street address 1310 W Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 19-03

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Whittington

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 52 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant: Benjamin Whittington
(b) Address 1310 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/28 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem
Location Frederick Rd

18 (a) Funeral director Joseph Kaisinskas Dead
(b) Address 202 Washington Blvd

19 DEC 27 1928 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1928, at 10 45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Brain
Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Feldmark M.D.
Medical Examiner.
Date signed 12/26/28

VS 131 c

X

G69842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69822

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2249 Reisterstown Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13-04

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2249 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES N. BRAMBLE

3 (b) If veteran, name war: 1ST World War
3 (c) Social Security Account No. –

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: MARGARET
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1887

8. AGE: Years 61 | Months 1 | Days | If less than one day hr. min.

9. Birthplace DORCHESTER COUNTY - MD
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name JAMES M BRAMBLE
13. Birthplace

MOTHER
14. Maiden Name SARA J. HURLOCH
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE NATIONAL
Location 5501 FREDERICK Ave.

18 (a) Funeral director THOMAS J. KENNY INC
(b) Address 1600 HOLLINS ST

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 26 1948, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from about 1935 to Dec 26 1948, and that I last saw h alive on Dec 26 1948.

Immediate cause of death: Coronary Thrombosis — Duration 4 hrs.
Due to: Arteriosclerotic H.D. — Duration Abt. yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Hightower
Address 888 W. Lombard St Date signed 12-27-48

VS 150

669823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 669823

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8017 High Point Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALTA LEE LUMPKIN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife James Lumpkin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1915

8. AGE: Years	Months	Days	If less than one day
33	5	5	hr. min.

9. Birthplace W. Va.
At. home (town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Bernard Farley
13. Birthplace W. Va.

MOTHER
14. Maiden Name Nora Crockett
15. Birthplace W. Va.

16 (a) Informant Mrs. Bernard Farley
(b) Address 8017 High Point Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/27/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lasvahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1948, at 12:05 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet-wound of abdomen.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-23-48 at ? P. M.
(b) Where did injury occur 8017 High Point Rd. Balto. County
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Firearms

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12-24-48

VS 151

X

G69824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69824

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4005 Fleetwood Ave.
(c) Hospital or institution: 27-05
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 Fleetwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KARL F. THALHEIM

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Freda A. Thalheim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26th, 1855

8. AGE: Years	Months	Days	If less than one day
93	6	27	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Cabinet maker
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Anna Leubecker
(b) Address 4005 Fleetwood Ave.

17 (a) burial (b) Date thereof 12/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Loeschin Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 December 1948, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to 22 Dec 1948, and that I last saw him alive on 22 Dec 1948.

Immediate cause of death Coronary Occlusion — Duration 24 hrs

Due to arteriosclerotic cardiovascular disease — 25 yrs.

Due to senile changes —

Other Conditions — None —

(Include pregnancy within 3 months of death)

Date of operation None —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward L. Thalheim M. D.
Address 7425 Harford Rd Date signed 23 Dec 48

Huntington Williams, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 669825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 17-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 550 Oxford Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH FRAZIER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March ?, 1903

8. AGE: Years	Months	Days	If less than one day
45	9		hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jeff Dives
13. Birthplace South Carolina

MOTHER
14. Maiden Name Catherine Ward
15. Birthplace South Carolina

16 (a) Informant Ward Benjamin
(b) Address 550 Oxford Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)

(c) Cemetery or crematory
Location Mt. Calvary.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Avenue

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1948, at 2.28 PM

21. I certify that I took charge of the remains described above, held an Inspection + Inq thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Pneumonia.
Uraemia.
Due to Carcinoma of the cervix uteri

Other Conditions over

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed December 23, 1948

VS 151

G69826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69826

1. PLACE OF DEATH: D-01
(a) Baltimore City, Maryland
(b) Street address 917 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.04
(e) Length of stay in Baltimore (yrs., mos., or days) 2.04

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian E. Leef

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Orville Leef
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1879

8. AGE: Years	Months	Days	If less than one day
68	0	1	hr. min.

9. Birthplace Greenville, S.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At. Home

FATHER
12. Name John Davis
13. Birthplace S.C.

MOTHER
14. Maiden Name (Unknown) Gaines
15. Birthplace S.C.

16 (a) Informant Orville Leef
(b) Address 5157 Stafford Rd.

17 (a) Burial (b) Date thereof 12/28/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto., Md.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 St. Paul St.

DEC 27 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1948 at 11:54 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V disease
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. F. Sulewski M.D.
Medical Examiner.
Date signed 12/26/48

VS 151

669827

BALTIMORE CITY HEALTH DEPARTMENT

LCH-123988

CERTIFICATE OF DEATH 186a

Registered No. 669827

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Frankford Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. SIPPLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Casper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/16/1869

8. AGE: Years	Months	Days	If less than one day
79	11	10	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Christopher Siefert
13. Birthplace Germany

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Baltimore Co. Funeral Home
(b) Address 1219 E. Fayette St.

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/48 19 , at 7:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23/48 19 to 12/26/48 19 , and that I last saw her alive on 12/26/48 19 .

Immediate cause of death	Duration
Broncho pneumonia	days
Due to Fracture Rt femur	2 mos.
Due to	
Other Conditions Diabetes mellitus	

CERTIFICATION APPROVED BY
Earl L. Kay M.D.
CHIEF MEDICAL EXAMINER

(Include pregnancy within 3 months of death)

Date of operation 10-27-48
Major findings of operation: Fracture Rt hip
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10-23-48 at 11 P.M.
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? house While at work?
(Specify type of place)
(e) Means of injury fall (Private home) (fracture hip)

23. Signature [illegible] M.D.
Address 49 to Eastern Ave Date signed 12-26-48

VS 150 TO BE APPROVED BY THE MEDICAL EXAMINER

X

9828 231350

BALTIMORE CITY HEALTH DEPARTMENT ✓ G69828 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 07
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Augusta Ln
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1897

8. AGE: Years	Months	Days	If less than one day
51	9	16	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name John Dorsey
13. Birthplace Va.

MOTHER
14. Maiden Name Rosie ?
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location 5500 Frederick Ave

18 (a) Funeral director Joseph S. Locke Jr.
(b) Address 1264 E. Centre Ave

19 (d) DEC 27 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1948, at 10 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1948 to Dec. 23 1948 and that I last saw him alive on Dec. 23 1948.

Immediate cause of death Congestive Heart Failure — Duration

Due to arteriosclerosis of the coronary arteries.

Due to

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman Mellinkoff M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 12/28/48

VS 150

X

G698c9

Medical Examiner's Case
BALTIMORE CITY HEALTH DEPARTMENT

J1- 125483

CERTIFICATE OF DEATH 186a

✓ G698c9 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Lee

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow (Stephen)

6 (b) Name of husband or wife Steven Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1864

8. AGE: Years	Months	Days	If less than one day
84	1	24	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Conrad Nies
13. Birthplace ? Germany

MOTHER
14. Maiden Name ? Cathrine — —
15. Birthplace ? Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Baltimore

18 (a) Funeral director Philip Sterling Sons
(b) Address 2024 Orleans St

19 (a) DEC 27 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1948, at 8.25 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1948 to Dec. 23 1948, and that I last saw her alive on Dec. 23 1948.

Immediate cause of death Carcinoma of Stomach & Perforation & generalized Peritonitis — Duration ?
Due to
Due to Fracture, neck, of femur
Other Conditions Cardiac Hypertrophy Dilatation & decompensation
(Include pregnancy within 3 months of death)
Date of operation 12/22/48
Major findings of operation: Ca of Stomach & generalized Peritonitis
of autopsy: as above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 6/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/19/48 ? at M
(c) Where did injury occur? Baltimore (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury Fall from bed to floor from high fever

23. Signature Frank S. Lawrence M. D.
Address Baltimore City Hosp Date signed 12/27/48

VS 150

To be approved by Medical Examiner 12/27/48 X

669850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. 669850

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1412 William St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 03

(e) Length of stay in Baltimore (yrs., mos., or days) 24

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1412 William Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Howard North

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White.

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Carrie North

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 13, 1862

8. AGE: Years 86 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Night Supt., retired

11. Industry or business Lord - Mott Co.

FATHER

12. Name Richard James North

13. Birthplace Md.

MOTHER

14. Maiden Name Frances E. Parrott

15. Birthplace Md.

16 (a) Informant Mrs. Wm. Lewis

(b) Address 1412 William St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/27/48 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) 12-27-1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1948 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23 1948 to Dec 23 1948 and that I last saw h im alive on Dec 23 1948.

Immediate cause of death Cardiac and Respiratory Failure — Duration

Due to Arteriosclerotic Cardio Vascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Lotus O. Hall

Address 2950 Edmondson M. D.

Date signed 12/28/48

VS 153

X

G69831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G69831

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Willowmere
(b) Street address 5414 ~~Windemere~~ Way
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5414 ~~Windemere~~ Way Willowmere
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LULA EMMA GRIPP

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Louis F. Gripp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 12, 1880

8. AGE: Years	Months	Days	If less than one day
68	4	11	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Wright
13. Birthplace Balto.

MOTHER
14. Maiden Name Fanny Baker
15. Birthplace Balto.

16 (a) Informant Mr. Louis F. Gripp
(b) Address Willowmere 5414 Windemere Way

17 (a) Burial (b) Date thereof 12/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS Balto., Md.
(b) Address

19 (a) DEC 27 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1948, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to Dec 23 1948, and that I last saw h e alive on Dec 23 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 4 yrs.
Due to arteriosclerosis — 5 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. S. Clafford
Address 610 York Rd Date signed Dec 24 '48 M. D.

VS 150

X

G69832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G69832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3110 Belmont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16-07

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Belmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN HENSEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Paulina Hensel (nee Mencken
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1859

8. AGE: Years	Months	Days	If less than one day
89	6	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Hensel, Sr.
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Broening
15. Birthplace Germany

16 (a) Informant Mrs. Walter L. O'Neill, daughter
(b) Address 3110 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24, 1948, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1948 to Dec 24 1948, and that I last saw h her alive on Dec 23 1948.

Immediate cause of death Myocardial insufficiency and degeneration

Due to Arteriosclerotic type heart disease with Coronary thrombosis

Due to Congestive failure

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 week
2 years
15 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Michel M. D.

Address 290 Edmondson Ave Date signed Dec 24 '48

VS 150

93D

G69833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G69833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3228 MONTEBELLO TERRACE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (64)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3228 MONTEBELLO TER.
(If rural give location)
(e) Citizen of foreign country? YES (Yes ~~or No~~)
If yes, name country RUSSIA (LUKOVKA)

3 (a) FULL NAME ANASTASIA KILUK

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife PETER KILUK

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN. 1884

8. AGE: Years 64 | Months 11 | Days ? | If less than one day ____ hr. ____ min.

9. Birthplace LUKOVKA, RUSSIA
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name DEMEDOWA SHEPTUR
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ?
15. Birthplace RUSSIA

16 (a) Informant CHRISTIANA BYCHUK
(b) Address 3228 MONTEBELLO TER.

17 (a) BURIAL (Burial, cremation, or removal) **(b) Date thereof** Dec. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory ST. ANDREWS RUSSIAN ORTHO.
Location OLD GERMAN HILL ROAD

18 (a) Funeral director Walter Burke Bradley
(b) Address 1922 W. North Avenue

19 (a) DEC 29 1948 (Date received by Registrar) **(b)** Huntington Williams, M.D. Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24/48 19 , at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Dec 24 1948, and that I last saw him alive on Dec 28 1948.

Immediate cause of death Carcinoma Lung — **Duration** 8 mo

Due to

Due to

Other Conditions Osteo - Carcinoma — 4 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Hergmann M.D.

Address 1710 E. 33 St. Date signed 12/24/48

X

/46

G69834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69834

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Yolando Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-03
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2339 McElderry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha B. Stout

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife George F. Stout
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16 - 1869

8. AGE: Years	Months	Days	If less than one day
79	2	10	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Bode
13. Birthplace Germany

MOTHER
14. Maiden Name Not known
15. Birthplace Not known

16 (a) Informant Elmer J. Stout
(b) Address 3725 Yolando Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) (Date received by Registrar) (b) Registrar

DEC 27 1948

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1948, at 12 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1948 to 12/26 1948, and that I last saw h EA alive on 12/18 1948.

Immediate cause of death	Duration
Heart failure	2 hrs
due to Hypertensive C-V disease	15 yrs
Due to also: Generalized Arterio sclerosis	3 mos
Due to Cysto-Pyelitis, Ascending due to ATONY OF BLADDER	11 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Arnold M. D.
Address 6919 Harford Rd Date signed 12/27/48

X

G69835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G69835

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21 N. Ellwood Ave.
(c) Hospital or institution: 6-01
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 N. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country naturalized

3 (a) FULL NAME John Adams Martin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Elizabeth Kobes (maiden)
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec 6- 1877

8. AGE: Years	Months	Days	If less than one day
71	-	19	hr. min.

9. Birthplace Germany (Town, county, and state or country)
10. Usual Occupation Copper Repairer (Retired)
11. Industry or business Balto. Copper works.

FATHER
12. Name Conrad Martin
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Bleuer
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth Martin
(b) Address 21 N. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1948 at 2.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1947 to Dec. 24 1948 and that I last saw him alive on Dec. 24 1948.

Immediate cause of death	Duration
Ca. Myocarditis	1 yr
Due to	
Due to Ca. Intestinal wall hernia	1948
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 1663 W. North Ave. Date signed 12/27/48

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G69836

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G69836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Hilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1m
(e) Length of stay in Baltimore (yrs., mos., or days) 61-2-21

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County DALTO
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 Overbrook Rd (28)
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Milton C. Poske

3 (b) If veteran, name war —
3 (c) Social Security Account No. ?

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife Anna
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) OCT 4-1887

8. AGE: Years 61 | Months 2 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business U.S. Post Office

FATHER
12. Name William Poske (Dec'd)
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Bushman
15. Birthplace Md

16 (a) Informant Mrs A. Poske
(b) Address 14 overbrook Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Grid 20
18 (a) Funeral director Geo H. Kellenbach
(b) Address 1726 N. Lyndhurst St.
19 (a) DEC 27 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1948, at 9 22 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1948 to 12/25 1948, and that I last saw him alive on 12/25 1948.

Immediate cause of death Cerebral hemorrhage — Duration
Due to Hypertensive CVD
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert J. Lemke M.D.
Address St Agnes Hosp Date signed 12/25/48

VS 150

G69837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G69837 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd
(c) Hospital or institution: Hartford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 5
(e) Length of stay in Baltimore (yrs., mos., or days) yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 Eugenia St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie Allen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	widowed

6 (b) Name of husband or wife Burgess B. Allen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14. 1859

8. AGE: Years	Months	Days	If less than one day
89		11 12	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Senf
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Ring
15. Birthplace Germany

16 (a) Informant Mrs. Clifford F. Fangmeyer
(b) Address 3407 Roselawn Ave

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 12/28/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cemetery
Location 1112 S. Bonsel St. Balto. Md.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 6009 Harford Road.

19 (a) DEC 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1948 at 1 35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cardio-Pulmonary Failure

Due to Arterio-sclerotic cardio vascular disease.

Other Conditions, Senility due to marked cerebral arterio-sclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B McCracken M.D.
Medical Examiner.
Date signed

VS 151

X

G69838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Fenway South, Riverdale Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY BERNARD JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/77

8. AGE: Years	Months	Days	If less than one day
71	-	7	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Retired R. R. Enginer

11. Industry or business

FATHER
12. Name George M. Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Hanna McVey
15. Birthplace Md.

16 (a) Informant: Elizabeth Jones
(b) Address 6 Fenway South, Riverdale Apts.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co

18 (a) Funeral director J. J. Brundage & Son
(b) Address 1967 Eastern Ave

19 (a) DEC 27 1948 (Accepted by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1948 at approx. 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royster M.D. Medical Examiner.
Date signed 12/27/48

VS 131

669839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 ✓

Registered No. 669839

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 647 S. Decker ave

(c) Hospital or institution: 1-0-r

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 647 S. Decker ave (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Leopoldyna (Lubawa) Stachowski

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Andrew Stachowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18 1868

8. AGE: Years	Months	Days	If less than one day
80	2	6	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Francis Kasprawicz

13. Birthplace Poland

MOTHER

14. Maiden Name Karolina Kapp

15. Birthplace Poland

16 (a) Informant Antoinette Style

(b) Address 647 S. Decker ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Balto. County

18 (a) Funeral director John M. Oliver

(b) Address 401 S. Chester street

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Burlington for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1948 at 5.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1948 to Dec. 24 1948 and that I last saw h alive on Dec. 24 1948

Immediate cause of death	Duration
GENERALIZED ARTERIOSCLEROSIS	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Benjamin Appleton M. D.

Address 124 S. HIGHLAND AVE Date signed 12/28/48

VS 150

669840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 669840

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3904 Helton Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 11
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 Helton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Michael Skalowsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1852

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Not known
13. Birthplace Russia

MOTHER
14. Maiden Name Not known
15. Birthplace Russia

16 (a) Informant Bertha Skalowsky
(b) Address 3904 Helton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-48 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Rogers Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 DEC 27 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1948 at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Dec 1948
and that I last saw h alive on Dec 26 1948

Immediate cause of death Coronary occlusion — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. **Signature** Irwin Sonta M. D.

Address 2002 Jumon Ave Date signed 12-27-48

VS 193

X

G6984-1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 134a

Registered No. G6984-1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkins ave
(c) Hospital or institution: St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State M. (b) County BALT
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Selma ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ulysses Duvall.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	M.

6 (b) Name of husband or wife Nancy Bohannan
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 23, 1869

8. AGE: Years	Months	Days	If less than one day
81	9	1	hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name Henry
13. Birthplace Virginia

MOTHER
14. Maiden Name Nancy Bohannan.
15. Birthplace Virginia

16 (a) Informant Above Mrs. Uhler
(b) Address 1810 Selma Ave -27

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/48 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington Va

18 (a) Funeral director Edw. S. MacNabb
(b) Address Catonsville Md

19 (a) DEC 27 1948 (Date received by Registrar) (b) Turnaturo for Mallahan, M.D. Registrar

VS 153

MEDICAL CERTIFICATION

35 A.

20. DATE OF DEATH 12-24- 1948 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1948 to 12/24 1948.
and that I last saw h/m alive on 12/23 1948.

Immediate cause of death Congestive failure with hypostatic pneumonia, rt.
Due to Arteriosclerotic cardiovascular disease
Due to
Other Conditions nephrolithiasis, hydronephrosis, left.
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Arteriosclerotic CVD

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hubert J. Lericka
Address St. Agnes Hosp. Date signed M.D. 12/24/48

93D

G69842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. G69842

Please write plainly with pen or pencil, and do not use abbreviations. The cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Sinai Hospital
(c) Hospital or institution:
15-06
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Ellamont St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tilda Tauba Blank

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	WW	Widow

6 (b) Name of husband or wife: Late Max
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: Unkown
13. Birthplace: Poland

MOTHER
14. Maiden Name: Unkown
15. Birthplace: Poland

16 (a) Informant: Milton Blank
(b) Address: 2516 Wycliffe Ave Roanoke Va.

17 (a) Burial (b) Date thereof Dec 29, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Atlanta Georgia
Location: Georgia

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) DEC 27 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1948, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25 1948 to 12-27 1948, and that I last saw h e alive on 12-27 1948.

Immediate cause of death	Duration
Cerebrovascular hemorrhage	
Due to Hypertensive Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hosp. Date signed 12-27-48

VS 150

669843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

Registered No. 669843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorail Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 das.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 8705 Raven Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WENDEL V. HARTSOCK

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Frances R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1924

8. AGE: Years	Months	Days	If less than one day
24	4	6	hr. min.

9. Birthplace Tenna (Town, county, and state)
10. Usual Occupation Bell Foundry Worker
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. W.V. Hartsock
(b) Address 8705 Raven Drive-Towson-4, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director LASSAHN FUNERAL HOME
(b) Address 7401 Belair Rd.

19 (a) DEC 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1948, at 12:07 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Carbon Monoxide Poisoning

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-23-48 at ? A.M.
(b) Where did injury occur? 8705 Raven Drive Towson, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhalation (of illuminating gas (Head in oven)

23. Signature Emil Kruger M.D. Medical Examiner
Date signed 12-27-48

Especially important: Physicians: please write the causes of death clearly and legibly.

G69844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G69844 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 N. Spring St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 N. Spring St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Scott.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9-1872

8. AGE: Years	Months	Days	If less than one day
76 73	5	14	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Scott Sr
13. Birthplace Md

MOTHER
14. Maiden Name Mary Weeks
15. Birthplace Md

16 (a) Informant Georgia M. Jones
(b) Address 1814 N Spring St

17 (a) Burial (b) Date thereof 12-27-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 DEC 27 1948 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1948 at 5h M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1948. to Dec. 23 1948.
and that I last saw h[illegible] alive on Dec. 23 1948.

Immediate cause of death: Chr. Pulmonary Tuberculosis — Duration: 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. L. Loy Jerry M. D.
Address 1420 E. Chase Date signed 12-27-48

VS 150

X

G69845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: S. Balto Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23-01
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Hanover St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William N Roby

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Caroline Roby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 19, 1867

8. AGE: Years	Months	Days	If less than one day
81	4	5	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired Claim Adjuster
11. Industry or business Insurance

FATHER
12. Name Charles J. Roby
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Tomlinson
15. Birthplace Balto Md

16 (a) Informant Charles N. Roby
(b) Address 1212 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location

18 (a) Funeral director A. Raquet Evans
(b) Address 1400 Eutaw Pl

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24, 1948, at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1948 to Dec 24 1948, and that I last saw him alive on Dec 24 1948.

Immediate cause of death	Duration
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature William T. Hamm M. D.
Address South Balto. Gen. Hosp. Baltimore 30, Md. Date signed 12-29-48

VS 150

G69846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3406 Woodbine Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3406 Woodbine Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER HOWARD TAYLOR

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-2491

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lucynda Jane Taylor Deceased

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 16, 1874

8. AGE: Years 74 | Months 11 | Days 9 | If less than one day: hr. min.

9. Birthplace Carroll County, Maryland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Adex Manufacturing Company

FATHER
12. Name James H. R. Taylor
13. Birthplace Carroll County, Maryland

MOTHER
14. Maiden Name Annie Tyoyer
15. Birthplace Maryland

16 (a) Informant Mrs. Mariana T. Brown (daughter)
(b) Address 3406 Woodbine Ave. Balt. 7, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1948 at 1 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1948 to Dec 25 1948 and that I last saw him alive on Dec. 24, 1948.

Immediate cause of death Congestive Heart Failure — Duration 12 hours

Due to Arteriosclerotic Cardiovascular Disease — Duration 10 years

Due to

Other Conditions Left hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None made

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Millard T. Trabandt

Address 3400 Woodbine Ave. 7 Date signed 12/25/48 M D

Registrar

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69847

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Dennlyn Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALICE R. MILES

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John W. Miles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1883

8. AGE: Years	Months	Days	If less than one day
65	9	12/13	hr. min.

9. Birthplace Howard Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Augustus Gover
13. Birthplace Howared Co., Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. John W. Miles
(b) Address 3404 Dennlyn Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1948 to 12/26 1948 and that I last saw h[illegible] alive on 12/26 1948.

Immediate cause of death	Duration
Coronary occlusion	
c myocardial infarction	
Due to arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: 12/28/48 Myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Fred Hawkins, Jr. M.D.
Address Franklin Square Hosp. Date signed 12/28/48.

VS 150

G69848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1098

Registered No. G69848

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2407 W. North Ave #16
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 15-03

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Malva Both Babcock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married.

6 (b) Name of husband or wife Reuben E.
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr) Nov. 23, 1886

8. AGE: Years	Months	Days	If less than one day
62	1	2 3	hr. min.

9. Birthplace Baltimore, Md.
(City, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Max Ball
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah (Lampheimer) Langheimer
15. Birthplace Balto.

16 (a) Informant Mr. Reuben E. Babcock
(b) Address 2407 W. North Ave.

17 (a) Burial (b) Date thereof Dec. 29, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory (Lorraine Cem. MARYLAND memorial Park
Location (Woodlawn Maryland 5801 Harford Rd

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 27 1948 (b) Lucretia Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1948, at 1:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25/1948 to 12/26/1948.
and that I last saw h alive on 12/26/1948.

Immediate cause of death Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard A. Blumberg M. D.
Address Date signed

VS 159

X

G69849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G69849

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Memorial Hosp.
(c) Hospital or institution:
27-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Beverly Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles S Shaffer, Jr.

3 (b) If veteran, name war none

3 (c) Social Security Account No. 218-22-6338

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Carolyn M. Shaffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1887

8. AGE: Years	Months	Days	If less than one day
61	1	28	hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business Kelly Springfield Tire Co.

FATHER
12. Name Charles S. Shaffer
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Charles S. Shaffer, Jr.
(b) Address 3207 Beverly Rd.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 12/28/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 27 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25-48 19 , at 11 15 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McGaddon M.D.
Medical Examiner.
Date signed 12-26-48

VS 151

X

669850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

P. 94a

Registered No. 669850

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hosp. 16-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Normount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James O'Farrell

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Marie H. O'Farrell

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 9/24/48 1901

8. AGE: Years: 47 Months: 3 Days: 1 If less than one day: hr. min.

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual Occupation: Chauffeur

11. Industry or business: Balto. City

FATHER
12. Name: James O'Farrell
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Mrs. Marie H. O'Farrell
(b) Address: 3106 Normount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Dec. 1948 at 8:30 P M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammer, Jr. M.D.
Medical Examiner.
Date signed 26 Dec. 48

VS 151

Typing, compositors, stenciling: please write the causes of death clearly and legibly.

6698:1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163M

Registered No. 6698:1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 763 McKewin Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9-03

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 763 McKewin Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD MEREDITH ANDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1924

8. AGE: Years	Months	Days	If less than one day
24	5	12	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles H. Anderson, Sr.
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Clara M. Edwards
15. Birthplace Baltimore, Maryland

16 (a) Informant C. H. Anderson
(b) Address 763 McKewin Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Maryland

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Maryland

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 19 48 at 10:20 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Carbon monoxide Poisoning

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-24-48 at 10:30 P. M.?
(b) Where did injury occur? 763 McKewin Avenue (Garage—rear of home)
(c) Did injury occur at home, on farm, industrial place, in public place? Garrage While at work? no
(d) Means of injury Carbon monoxide (Ignition on car closed)

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12-27-48

VS 151

G698:52

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 B

Registered No. G698:52

GM. 124330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 11-0V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 W. Preston ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel Woodrow

3 (b) If veteran, name war

3 (c) Social Security Account No. 207-07-9108

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27 1893

8. AGE: Years	Months	Days	If less than one day
55	7	27	hr. min.

9. Birthplace PA. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harvey (D (
13. Birthplace MD.

MOTHER
14. Maiden Name Margaret Barker
15. Birthplace PA.

16. (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Road

18 (a) Funeral director Joseph Fanaro, Inc.
(b) Address 2413 Fleetwood Ave.

19 (a) DEC 27 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 24-48 19 . at 6.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5- 1948 to 12- 24- 1948, and that I last saw h im alive on 12- 24- 1948

Immediate cause of death Pulmonary Tuberculosis F.A. Unilateral — Duration yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Boarman M.D.
Address Balto City Hosp Date signed 24 Dec 48

VS 199

6698:53

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 6698:53

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 S. Highland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 76-09

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 S. Highland Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH K. LONG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	WIDOWED.

6 (b) Name of husband or wife Cooper Long.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1872.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	2	29		

9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business House-Work.

FATHER
12. Name Conrad Smith
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto. Co., Md.

16 (a) Informant Joseph Long (Son)
(b) Address 3815 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Mem. Park
Location Eastern Ave.

18 (a) Funeral director Charles S. Zeiler
(b) Address 901 S. Conkling St.

19 DEC 27 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23- 1948, at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1948 to Dec 23 1948, and that I last saw her alive on Dec 22 1948.

Immediate cause of death Hypostatic Congestion
Arteriosclerotic C.V. Disease
Cerebral Hemmorrhage — Duration 12-12-48 / Dec 22-48

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eva Schumacher M. D.

Address 842 S. Ann St. Date signed 12-24-48

VS 150

X

G69854 — 937 — Registered No. 26698

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 16-06

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town 2835 Rayner Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore 16 · md. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Clara Louise Gebhart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Allen.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 1/1/87

8. AGE: Years 71 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Chas. Thompson
13. Birthplace: Germany.

MOTHER
14. Maiden Name: Anna
15. Birthplace: Md.

16 (a) Informant: Family
(b) Address: Same.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery or crematory: Catholic
Location: Mt. Freedom R.C. Cem.

18 (a) Funeral director: L. McCully
(b) Address: 1302 E. Fort Ave.

DEC 27 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1948, at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1948 to 12/24 1948, and that I last saw h.E.R. alive on 12/24 1948.

Immediate cause of death: Cerebro-vascular Accident Thrombosis or Hemorrhage?
Due to: Arteriosclerosis C-V.D.
Due to:
Other Conditions: Left hemiplegia Unconsciousness Left femoral paralysis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: William J. Vonsch M. D.
Address: Bon Secours Hosp. Date signed 12/24/48

VS 150

X

G69855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

116

Registered No. G69855

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or Institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Just entered

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1740 Clarkson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Ireland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: — Margaret
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) — 5-16-18[illegible]
8. AGE: Years 73 | Months 7 | Days 8 | If less than one day: hr. min.
9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John Ireland
13. Birthplace —

MOTHER
14. Maiden Name Laura —
15. Birthplace —

16 (a) Informant Hospital records
(b) Address

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director J. H. McCully
(b) Address 130 E. Fort Ave.

19 (c) DEC 27 1948 (Date rec'd) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1948, 11.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1948 to Dec 24 1948 and that I last saw him alive on Dec 24 1948.

Immediate cause of death: Heart failure
Pulmonary edema
Due to
Due to
Other Conditions: Cirrhosis of liver
Arteriosclerosis - hypertension
(Include pregnancy within 3 months of death)

Duration: 10 hrs.

Date of operation
Major findings of operation:
of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. Shumaker M.D.
Address Mercy Hosp. Date signed 12/24/48

VS 159

111c

GRACE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

Registered No. 669856

669856

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 James St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 75-0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 James St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl E Grace

3 (b) If veteran, name war: Yes.

3 (c) Social Security Account No. 205-05-0990

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 24 1895

8. AGE: Years 53 | Months 13 | Days 702 | If less than one day ... hr. ... min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name William Grace
13. Birthplace Balto

MOTHER
14. Maiden Name Ida —
15. Birthplace Md.

16 (a) Informant Earl Grace Jr.
(b) Address 1521 Fange St Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Rd

18 (a) Funeral director Edward Foulson
(b) Address 2239 Wash Blvd

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1948, at 8 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1948 to Dec. 26 1948, and that I last saw him alive on Dec. 26 1948.

Immediate cause of death Hodgkins Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Arthur Rosberg M. D.
Address 2411 Wash. Blvd Date signed 12/27/48

VS 150

Physicians: please write the causes of death clearly and legibly.

G69857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G69857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County Cumberland
(c) City or town Camp Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. 2166 Market Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALFRED W. GREENWOOD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 25, 1891

8. AGE: Years	Months	Days	If less than one day
57	1	1	hr. min.

9. Birthplace Altoona, Pennsylvania (Town, county, and state)
10. Usual Occupation Retired laborer
11. Industry or business Pennsylvania R.R.

FATHER
12. Name Ralph Henry Greenwood
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Jennie E. Wilmer
15. Birthplace Pennsylvania

16 (a) Informant Mr. John E. DeGrange
(b) Address Route 4, Box 73, Elkridge, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-27-48 (month) (day) (year)
(c) Cemetery or crematory Harrisburg Cem.
Location Harrisburg, Pa.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 (a) Dec 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948, at 1.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12/24/48

VS 151

Physicians: Please write the causes of death clearly and legibly. The accuracy of this certificate is extremely important.

6698-38 ✓ 6698-38

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 South Bond Street
(c) Hospital or institution:
Home 2.01
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 South Bond Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mrs. Anna Zacharski

3 (b) If veteran, name war .....

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Andrew Zacharski
6 (c) If alive, give address ~~Deceased~~

7. Birth date of deceased (mo., day, yr) July 24 1858 ?

8. AGE: Years	Months	Days	If less than one day
About 90 ?	5	1	..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Kozlowski
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Sophia Szymanski
(b) Address 1519 Lancaster Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) 12/27/48 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26th 1948, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1948 to Dec. 25 1948, and that I last saw him alive on Dec. 24 1948.

Immediate cause of death	Duration
Bilateral Bronchopneumonia (Terminal)	
Anna Zacharski	
Due to	
Due to	
Other Conditions ..... (Include pregnancy within 3 months of death)	

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Dr. A. Kenderski M. D.
Address 2284 Eastern Ave. Date signed .....

VS 180

X

6698 9 ✓ 6698 9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 821 S. Montford Ave
(c) Hospital or institution:
Home 1-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 S. Montford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander B. Baranowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-3083

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March / ? 1878

8. AGE: Years	Months	Days	If less than one day
70	9		hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Matthew Baranowski
13. Birthplace Poland

MOTHER
14. Maiden Name Apolonia / ?
15 Birthplace Poland

16 (a) Informant Mrs. Anna Baranowski
(b) Address 821 South Montford Ave

17 (a) Burial (b) Date thereof 12-29-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) 12/27/48 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26th 1948, at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23, 1948 to Dec. 26 1948. and that I last saw h alive on Dec. 25, 1948.

Immediate cause of death	Duration
(a) Carcinoma - gastric (?) -	?
(b) - Anuria & uremia -	about 3 days
Due to Arteriosclerosis	
Due to Myocardial failure	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan H Shnay M.D.
M. D.
Address 1810 Eutaw Pl. Date signed 12/27/48

VS 196

Physicians: please write the causes of death clearly and legibly.

G69860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G69860

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 Old Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES VICTOR FONZI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Pearl McMullen

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) June 20, 1888

8. AGE: Years 60 | Months 6 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace France
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Mrs. Pearl Fonzi
(b) Address 2120 Old Eastern Avenue

17 (a) Removal (b) Date thereof 12/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Port Royal.
Location Penn.

18 (a) Funeral director John S Connelly
(b) Address 418 Saturn Ave. Towson, Md

19 DEC 21 1948 (b)
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1948, at 2:20P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. B. Helfrich, M.D. per [illegible] M.D.
Medical Examiner.

Date signed 12-27-48

G69861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G69861
Registered No.

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH: Edlucation Hgts.
(a) Baltimore City, Maryland
(b) Street address 2300 Edlucation Hgts
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 16-05

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Edlucation Hgts
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie B. Gilbert.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Widowed

6 (b) Name of husband or wife Charles S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-13-1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
73	10	10		

9. Birthplace Laurel Md
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business At Home

FATHER
12. Name Thomas Baldwin
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Margaret Heise
15 Birthplace Pa

16 (a) Informant Rehna Reninger
(b) Address 1931 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 27 Dec 48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director F. A Wippert & Son
(b) Address 1300 Eutaw Place

DEC 24 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1948, at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Dec 22 1948
and that I last saw her alive on Dec 22 1948

Immediate cause of death Arteriosclerotic C-V disease — Duration 1 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. P. Lubinski M. D.
Address 1945 W Balto Date signed 12/24/48

C. W. Lubinski X

G69862 ✓ G69862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 457

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Avenue
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 732 Northern Pkwy.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME John Michael Gill, Sr.

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Hermina Bishop
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
72			..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Mgr. H. Bishop Co
11. Industry or business .....

FATHER
12. Name Peter Gill
13. Birthplace Ireland

MOTHER
14. Maiden Name (?)
15 Birthplace (?)

16 (a) Informant Mr. John M. Gill, Jr.
(b) Address 732 Northern Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location .....

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE. & 22nd ST. BALTIMORE - 18, MARYLAND

19 (a) Date received DEC 27 1948 (b) registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH Dec. 23rd 1948, at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1945 to Dec 23 1948.
and that I last saw h[illegible] alive on Dec. 18 1948.

Immediate cause of death: Myocardial Insufficiency — Duration 2 yrs.
Due to Arteriosclerosis, Generalized — 2 yrs.
Due to .....
Other Conditions: Carcinoma, Left Jaw Bone, Senility
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work? .....
(e) Means of injury .....

23. Signature H. Lon. Primakoff M.D.
Address Emerson and Pls. Date signed 12/27/48.

VS 150

93E

G6983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G6983

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days) 20-07

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 Lyndhurst Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWARD R. THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Inez E. Tyler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1885

8. AGE: Years	Months	Days	If less than one day
63	6	29	hr. min.

9. Birthplace Deals Island, Md. (Town, county, and state)
10. Usual Occupation District Superintendent
11. Industry or business Tidewater Fishery of Maryland

FATHER
12. Name Wilber J. Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Frances
15. Birthplace Maryland

16 (a) Informant Inez E. Thomas
(b) Address 310 Lyndhurst Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Maryland

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Avenue

19 DEC 27 1948 (Date rec'd by registrar) (b) Registrar

VS 151

Lantington for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24, 1948, at 6:40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull & intra-cranial hemorrhage
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/24/48 at 5:10 P.M. 20/7
(b) Where did injury occur? Normandy & Edmondson Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work?
(d) Means of injury Pedestrian struck by auto.

23. Signature Earl Royer M.D.
Medical Examiner. VB
Date signed December 27, 1948

X

G69864

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. G69864

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 RUSSELL ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 41 0

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 RUSSELL ST.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME GEORGE LIND

3 (b) If veteran, name war	3 (c) Social Security Account No.
SPANISH AMERICAN WAR	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife GERTRUDE
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) MARCH 24, 1875

8. AGE: Years	Months	Days	If less than one day
73	9	2	hr. min.

9. Birthplace OHIO
(Town, county, and state)
10. Usual Occupation PAINTER
11. Industry or business

FATHER
12. Name GEORGE LIND
13. Birthplace GERMANY

MOTHER
14. Maiden Name ROSA SCHWINDT
15. Birthplace UNKNOWN

16 (a) Informant GERTRUDE LIND
(b) Address 1206 RUSSELL ST.

17 (a) BURIAL (b) Date thereof 12-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory PORTS. NATIONAL CEM.
Location FREDERICK AVE.

18 (a) Funeral director Joseph F. Cornelius Co.
(b) Address 2424 Gulph Spring Rd. Baltimore, Md.

19 (a) 12-27-1945 (b) Filed by Registrar
(Date received by Registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1945, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1945 to 12/26 1945, and that I last saw him alive on 12/26 1945.

Immediate cause of death

	Duration
Acute Cardiac Failure	1 da
Due to Coronary Arteriosclerosis	yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph G. Cornelius M. D.
Address 1 W. Washington St. Date signed 12/27/45

G69865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G69865

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5118 Edmondson ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5118 Edmondson
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Clarence E. Burton ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Janet Rinaca Burton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 - 1889

8. AGE: Years	Months	Days	If less than one day
59	2	23	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Church furnishings

FATHER
12. Name Elijah Burton
13. Birthplace Md

MOTHER
14. Maiden Name Carlisle
15. Birthplace

16 (a) Informant Mrs. Janet R. Burton
(b) Address 5118 Edmondson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1512 Hollins St

19 DEC 27 1948 (Date filed by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1948, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 1946, to 12/23 1948, and that I last saw h[illegible] on 12/22/1948.

Immediate cause of death Pulmonary Oedema

Due to Coronary Thrombosis

Due to —

Other Conditions Coronary Disease Hypertension and Arteriosclerosis
(including pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature James R. Crouse M.D.
Address 72 Medical Arts Date signed 12-27-48

VS 150

95c

G69866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G69866

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 W. Mulberry St.
(c) Hospital or institution:

18 01

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Simon Washington.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	Widower.

6 (b) Name of husband or wife Bertha Washington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1883.

8. AGE: Years	Months	Days	If less than one day
65	5	22	hr. min.

9. Birthplace Dorchester County, Va.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Virginia

MOTHER
14. Maiden Name ?
15. Birthplace Virginia.

16 (a) Informant Anna Washington.
(b) Address 911 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 DEC 21 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1948, at 4 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1948 to 12/23 1948. and that I last saw h[illegible] alive on 12/22 1948.

Immediate cause of death: Bronchopneumonia Carcinoma of Prostate — Duration ?

Due to

Due to

Other Conditions: Arteriosclerosis Congestive
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Carter
Address 23 Gorsuch Date signed 12/24/48

VS 150

669867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. 669867

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 Whitelock St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 to 3
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Whitelock St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Rouse

3 (b) If veteran, name war 0

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Married

6 (b) Name of husband or wife John Rouse

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1898

8. AGE: Years	Months	Days	If less than one day
50	7	3	hr. min.

9. Birthplace Hague Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Gordon
13. Birthplace Hague Va.

MOTHER
14. Maiden Name Rosil ?
15. Birthplace Hague Va.

16 (a) Informant John Rouse
(b) Address 1506 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28, 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 27 1948 (Date rec'd by registrar) Thomas J. Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1948, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 25 '48 to Dec 23 1948. and that I last saw her alive on Dec 23 1948.

Immediate cause of death	Duration
Cardiovascular atonic C metastasis.	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. S. Julian Jr. M. D.
Address 5 W. N. Schroeder St. Date signed 12/24/48

VS 150

X

66988

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

Registered No. 66988

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 948 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 948 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Holton.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Pauline Holton.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1901

8. AGE: Years	Months	Days	If less than one day
47	6	12	hr. min.

9. Birthplace Scribner County, Ga.
(Town, county, or state)
10. Usual Occupation Truck Driver, P.P. Railroad
11. Industry or business

FATHER
12. Name Robert Holton,
13. Birthplace Waycross Ware Co. Ga.

MOTHER
14. Maiden Name Ross
15. Birthplace Ga.

16 (a) Informant Pauline Holton.
(b) Address 948 W. Saratoga St

17 (a) Burial (b) Date thereof Dec. 27 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 27 1948 Thurston for Williams, Mgr.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1948, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Dec 23 1948, and that I last saw him alive on Dec 22 1948.

Immediate cause of death	Duration
Congestive Heart Failure	Appx 1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Garland Chinelly M. D.
Address 902 W. Franklin Date signed 12-24-48

VS 193

X

G69869

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. G69869

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 753 McKewin Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9.03
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 753 Mc Kewin Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Seebach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John B. Seebach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1862

8. AGE: Years	Months	Days	If less than one day
86	5	-	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business at Home

FATHER
12. Name Gregory Schaefer
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Germany

16 (a) Informant Elizabeth B. Seebach
(b) Address 753 Mc-Kewin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Loch Raven

18 (a) Funeral director John E Moran
(b) Address 3000 E Baltimore St

19 DEC 27 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 - 1948 at 5.40 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1946 to Dec 24 - 1948, and that I last saw her alive on Dec 24 1948.

Immediate cause of death	Duration
Bronchs - pneumonia (Bilateral)	
Due to Cardio - renal - vascular disease	
Due to Hypertension; arterio sclerosis	
Other Conditions Senility.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manuel Sodaro
Title Address 4624 York Road Date signed 12/25/48 M. D.

VS 150

X

G69870
J1 - 121621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G69870
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 9-06
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1741 E. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace L. Gaines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1879

8. AGE: Years	Months	Days	If less than one day
69	2	7	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name A. A. Simering
13. Birthplace Md.

MOTHER
14. Maiden Name Nellie Grant
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location RITCHIE HIGHWAY

18 (a) Funeral director CLARENCE F. HOFFMAN
(b) Address 639 Broadway

19 DEC 27 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1948, at 12.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1948, to Dec. 25 1948, and that I last saw her alive on Dec. 25 1948.

Immediate cause of death	Duration
Uremic Coma	36 hrs.
Due to Hypertensive Arteriosclerotic cardio vascular renal disease	years
Due to	
Other Conditions Pulmonary Tuberculosis - Bilateral	6 mo. t.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M. D.
Address Balt. City Hosp. Date signed 12-22-48

VS 150

131a

G6987.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G6987.1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution:
University Hospital 11-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) about 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Isadora Hoskins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William G. Hoskins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1860

8. AGE: Years	Months	Days	If less than one day
88	8	25	hr. min.

9. Birthplace Upper Falls, Balto. County, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Bradford Chenoweth
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara Emory
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Stanhope Hoskins
(b) Address 3738 Tudor Arms Ave.

17 (a) Burial (b) Date thereof 12/29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Friends Meeting House
Location Fallston, Maryland

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 DEC 27 1948 Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1948, at 7 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1948 to Dec 26 1948 and that I last saw her alive on Dec 26 1948

Immediate cause of death Cardiac failure

Due to Arteriosclerosis & Hypertensive cardiovascular disease

Due to

Other Conditions Lobar pneumonia, fracture left femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

CERTIFICATION APPROVED BY
George G. Merrill M.D.
FOR
CHIEF OR ASST. MEDICAL EXAMINER

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 11/4
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12-12-48 at 7 P. M
(c) Where did injury occur? 1210 Linden Ave.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no
(Specify type of place)
(e) Means of injury

23. Signature Frank E. Eisenberg M. D.
Address University Hospital Date signed 12/26/48

VS 150

X

6698.72

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6698.72 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2618 N. Calvert St.
(c) Hospital or institution:
none 12-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Sara E. Hyland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1867

8. AGE: Years	Months	Days	If less than one day
81	—	15	hr. min.

9. Birthplace Elk Neck Cecil Co. Md.
(Town, county, and state)
10. Usual Occupation Proprietress- Roomng House
11. Industry or business

FATHER
12. Name Absalom Hyland
13. Birthplace Cecil Co. Md.

MOTHER
14. Maiden Name Anne Colt
15. Birthplace Talbot or Queen Anne Co. Md.

16 (a) Informant Miss Laura E. Hyland
(b) Address 2618 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery Hart's M. E. Church
Location Cecil County, Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (Signature of local registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1948, at 8.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 25, 1948 to Dec. 26, 1948, and that I last saw her alive on Dec. 26 1948.

Immediate cause of death Cerebral Hemorrhage — Duration Immediate

Due to Cerebral Sclerosis — ?

Due to Hypertension — ?

Other Conditions ✓

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: ✓

of autopsy: ✓

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓
(Specify type of place)
(e) Means of injury ✓

23. Signature Frank H. Ogden, M. D.
Address 2701 N. Calvert St. Date signed

VS 150

Please answer all questions. Information should be carefully supplied. Coverage is especially important. Physicians: please write the causes of death clearly and legibly.

G69873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk 6 1
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 W. 29th ST.
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE ALEXANDRA RAPP

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1857

8. AGE: Years	Months	Days	If less than one day
91	4	1	hr. min.

9. Birthplace DARMSTADT, GERMANY
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Joseph Rapp
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Uhlefenbach
15. Birthplace Germany

16 (a) Informant Mrs. Adele J. Ritter
(b) Address 725 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. C. Mears and Son
(b) Address 805 N. Calvert St.

19 DEC 27 1948 (Date rec'd by registrar) (b) Huntington for Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948, at 9:55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 1948 to Dec 26, 1948. and that I last saw h CR alive on Dec. 26 1948.

Immediate cause of death	Duration
Acute Coronary Thrombosis	
Due to Arteriosclerotic Cardio-vascular Disease	
Due to Arterio Sclerosis Generalized.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker Jr. M. D.
Address St. Joseph's Hospital Date signed 12-26-48

VS 150

G69874

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92a ✓ Registered No. G69874

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 E. Madison St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-0-5
(e) Length of stay in Baltimore (yrs., mos., or days) 7-0-5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: (Rev.) Loudon Scruggs. Loudon Scruggs

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 224-22-0406

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude Scruggs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1898

8. AGE: Years 50 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co

FATHER
12. Name Ellison Scruggs
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Wright
15. Birthplace Unknown

16 (a) Informant: Gertrude Scruggs
(b) Address 1809 E. Madison St

17 (a) Shipment (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)

(c) Cemetery or crematory
Location Appomattox Va.

18 (a) Funeral director Robert F. Young
(b) Address 1216 N. Caroline St.

19 (a) DEC 27 1948 (b) Signature of local registrar Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1948, at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1948 to Dec 24 1948, and that I last saw him alive on Dec 23 1948.

Immediate cause of death: (a) Coronary Embolism (Duration: a few hrs.)
Due to: (b) Auricular Fibrillation (Duration: Sept 1948)
Due to: (c) Hemiplegia, Aortic Insufficiency
Other Conditions: Aortic Stenosis.
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph L. Young M. D.
Address 1424 E. Monument Date signed 12/26/48

VS 150

820

G69875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G69875 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County HARFORD
(c) City or town Aberdeen (If outside city or town limits, write RURAL and give town)
(d) Street No. R 7 D #1 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Frank McCarney

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Alice Ewing
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) May 27, 1902

8. AGE: Years	Months	Days	If less than one day
46	7	0	____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Mr. Frank McCarney
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Rollins
15. Birthplace Baltimore, Maryland

16 (a) Informant The patient - Mrs
(b) Address de Ceased

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30-1948 (month) (day) (year)
(c) Cemetery or crematory Baker's
Location Aberdeen Md

18 (a) Funeral director Henry Fanning Sons
(b) Address Aberdeen Md

19 (a) DEC 27 1948 (Rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1948, at 9:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1948 to Dec 27 1948 and that I last saw him alive on Dec 27 1948.

Immediate cause of death Anuria due to Pulmonary edema, st. Glomerulonephritis, left ATELECTASIS
Due to Chronic obstructive bronchitis.
Due to
Other Conditions Post. op. total gastrectomy for ca 8 years
(Include pregnancy within 3 months of death)

Duration

Date of operation 12-18-48
Major findings of operation: Ca of stomach
of autopsy: Confirmed clinic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Robert Haase M. D.
Address Church Home + Hosp. Date signed 12-27-48

VS 153

G69876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170

Registered No. G69876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore Md.
(If outside city or town limits write RURAL and give town)
(d) Street No. 800 N. Belnord Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kernan, John H

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/28/1883

8. AGE: Years	Months	Days	If less than one day
65	3	27	hr. min.

9. Birthplace Baltimore, Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name John H. Kernan
13. Birthplace

MOTHER 14. Maiden Name Catherine A.
15. Birthplace

16 (a) Informant Mr. Edgar Thibou
(b) Address 800 N. Belnord Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1948, at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1948 to 12/25 1948, and that I last saw h/m alive on 12/25 1948

Immediate cause of death Pulmonary edema
post operative

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12/23/48, gastroenterostomy
Major findings of operation: Gastric ulcer
old posterior perforation
of autopsy: Pulmonary edema, [illegible]

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Fred Hawkins, Jr. M. D.
Address Franklin Square Hosp. Date signed 12/27/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

Dr. Sawyer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G6598.47

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3017 Pinewood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Pinewood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Mitchell Lill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John W. Lill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1884

8. AGE: Years	Months	Days	If less than one day
64	6	13	hr. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Robert Wishart
13. Birthplace Scotland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. John W. Lill
(b) Address 3017 Pinewood Avenue

17 (a) Burial (b) Date thereof 12-26-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Washington Willis, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26th 1948, at 8 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1948, to Dec 26 1948 and that I last saw her alive on Dec 24 1948.

Immediate cause of death Carcinoma of Breast — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Sawyer M. D.

Address 4808 Harford Rd. Date signed 12/26/48

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

9878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 66978

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-07
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Abbotson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John F Hornick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Elsie Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3-1892

8. AGE: Years	Months	Days	If less than one day
56	0	23	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B & O. R.R.

FATHER
12. Name Henry B. Hornick
13. Birthplace Pa.

MOTHER
14. Maiden Name Ida E. Beckwith
15. Birthplace Md.

16 (a) Informant Mrs. Elsie J. Hornick
(b) Address 1514 Abbottston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 DEC 27 1948 (Date rec'd by registrar) Courtney Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1948, at 5 03 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Heart Disease

Due to Mild Hypertension C.V.D.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D. Medical Examiner.

Date signed 12-26-48

VS 151

X

Dr. Mendelis
651 N. Bentalou St

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G69879

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 N. Linwood Avenue
(c) Hospital or institution:
7-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 N. Linwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Frank Murphy Dowell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1870

8. AGE: Years	Months	Days	If less than one day
78	8 7	9	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation self employed
11. Industry or business

FATHER
12. Name William B. Dowell
13. Birthplace Md.

MOTHER
14. Maiden Name Cornelia Turner
15. Birthplace Md.

16 (a) Informant Mrs. Mary E. Dowell
(b) Address 813 N. Linwood Avenue

17 (a) Burial (b) Date thereof 12-28-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) DEC 27 1948 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Dec 26 1948 and that I last saw him alive on Dec 26 1948

Immediate cause of death: Cerebral Thrombosis — Duration: 3 weeks
Due to: Cerebral Sclerosis
Due to:
Other Conditions: Coronary Heart Disease — Duration: years
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. J. Mendelis
Address 651 N Bentalou Date signed 12/27/48 M. D.

VS 189

8313

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 6380

6380

PRINT CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 88 days
(e) Length of stay in Baltimore (yrs., mos., or days): 88 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: CECIL
(c) City or town: Elkton
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 115 E. High St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: WILLIAM HENRY BIDDLE

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.: 221-09-0866

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 7, 1894

8. AGE: Years	Months	Days	If less than one day
54	3	20	hr. min.

9. Birthplace: Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: Thomas Biddle
13. Birthplace: Md.

MOTHER
14. Maiden Name: Martha Kirk
15. Birthplace: Del.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 27 1948 (month) (day) (year)
(c) Cemetery or crematory:
Location: Elkton

18 (a) Funeral director: H. W. Pippin & Son
(b) Address: Elkton, Md.

19 DEC 27 1948 (Date rec'd by local registrar) (b) Huntington-Wilson, Inc.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 27 1948, at 1:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1948, to Dec. 27 1948, and that I last saw him alive on Dec. 27 1948.

Immediate cause of death: Chronic myelogenous leukemia — Duration: Unknown

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address: Clinical Director Date signed 12/27/48

VS 150

669851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. 669851

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 819 Hollins St

(c) Hospital or institution: 18-03

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 819 Hollins St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Anele Mazeika

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex	5 Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Simas Mazeika

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not know

8. AGE: Years	Months	Days	If less than one day
62 yrs.			hr. min.

9. Birthplace Lithuanian (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name not known

13. Birthplace Lithuanian

MOTHER

14. Maiden Name Not know

15. Birthplace Lithuanian

16 (a) Informant Mrs Nellie Johnson

(b) Address 1443 Saratoga St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec. 28-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location 4600 Eastern Ave

18 (a) Funeral director John A Grefenecky Jr

(b) Address 423 S. Paca St

19 DEC 27 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1948 at 9:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1948 to Dec 24 1948.

and that I last saw her alive on Dec 24 1948.

Immediate cause of death Chronic Myocarditis & Myocardial degeneration — Duration 6 mos

Due to Cirrhosis of Liver — Duration 4 yrs

Due to

Other Conditions Uncertain (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John P. Ulrich Jr

Address 1220 Wash Blvd Date signed 12/29/48

VS 150

65882

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

Registered No. 65882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5112 Ludale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME E. Elizabeth Kulpa

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Jack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1906

8. AGE: Years	Months	Days	If less than one day
42	11	5	hr. min.

9. Birthplace South Carolina (City or county, and state)
10. Usual Occupation Employment
11. Industry or business Sterling Elect Co

FATHER
12. Name Talleah J. (Mohammed)
13. Birthplace S C

MOTHER
14. Maiden Name Mahoney
15. Birthplace S C

16 (a) Informant Jack Kulpa
(b) Address 5112 Ludale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/48 (month) (day) (year)
(c) Cemetery or crematory West Minster
Location West Minster Md
18 (a) Funeral director Thomas & Lee
(b) Address 1219 E Fort Ave
19 (a) DEC 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Dec 1948, at 7:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Dec 1948 to 27 Dec 1948, and that I last saw her alive on 27 Dec 1948.

Immediate cause of death Generalized Carcinomatosis from ca of breast

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature V. P. Young
Address V.A.B.C. Hospital Date signed 27 Dec 48

VS 150

G69883

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G69883
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4817 Forest Park Ave.
(c) Hospital or institution:
28.03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4817 Forest Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTA O. LEE

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1863

8. AGE: Years	Months	Days	If less than one day
85	7	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Chrystal
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Clark
15. Birthplace Baltimore, Md.

16 (a) Informant John S. Crystal
(b) Address 4817 Forest Park Ave.

17 (a) Burial (b) Date thereof 12/28/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 28 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1948 19 , at 9:00 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1948 to Dec 24 1948 and that I last saw h[illegible] alive on Dec 24 1948

Immediate cause of death [illegible] — Duration 2 days
Due to [illegible] — 28 years
Due to
Other Conditions [illegible] — 5 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 4509 Liberty Pkwy Date signed Dec 27

VS 150

X

659884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 659884

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 14
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 Hillside Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STELLA A. HARTE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife Dr. Edwin A. Harte
6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) May 14, 1878

8. AGE: Years	Months	Days	If less than one day
70	7	13	hr. min.

9. Birthplace Wilkes Barre, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Cannon
13. Birthplace Pa.

MOTHER
14. Maiden Name Jane Edwards MacDonald
15. Birthplace Pa.

16 (a) Informant Mrs. John Magee
(b) Address 14 Hillside Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Wilkes Barre, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 28 1948 (Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to Dec 27 1948. and that I last saw her alive on Dec 14 1948.

Immediate cause of death	Duration
Cerebral arterio-sclerosis	
Due to Arterio-sclerosis (General)	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: ~

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence no at M
(c) Where did injury occur? no (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? no (Specify type of place) While at work? ~
(e) Means of injury: none

23. Signature A. Conrad Strett M.D.
Address 712 Park Ave. Balto. 1, Md. Date signed 12/28/48 M D Y

VS 150

669885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

669885 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway at Fairmount
(c) Hospital or institution Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Grant
(c) City or town Bayard
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ardel E. Mullennex

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs. Florida Mullennex
6 (c) If alive, give age 5 years

7. Birth date of deceased (mo., day, yr.) June 15, 1891

8. AGE: Years	Months	Days	If less than one day
57	6	11	hr. min.

9. Birthplace Cinnabar, W. Va. (Town, county, and state)
10. Usual Occupation W. Va. State Dept. Mines
11. Industry or business Mining

FATHER
12. Name William L. Mullennex
13. Birthplace Staunton, Va.

MOTHER
14. Maiden Name Elizabeth Bennett
15. Birthplace Franklin, W. Va.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-48 (month) (day) (year)
(c) Cemetery or crematory Bayard Cem.
Location Bayard W. Va.

18 (a) Funeral director Jack Lewis Inc.
(b) Address 2160 Ontario Place

19 (a) DEC 28 1948 (Date rec'd by registrar) (b) Huntington Williams Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26-48 19 , at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 19 48 to 12-26 19 48, and that I last saw him alive on 12-26 19 48.

Immediate cause of death	Duration
Pulmonary Embolus	instantaneous
Due to Post Operative Cholecyst gastrostomy	5 days
Due to Carcinoma head of Pancreas	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12-20-48
Major findings of operation: Carcinoma head of Pancreas
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Church Home & Hospital Signed 12-26-48

VS 153

69886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 69886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town ~~Baltimore~~ MIDDLEBORO
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 250 MILES RD. Route 6
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL FISHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED.

6 (b) Name of husband or wife Bertha E. Fisher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 29, 1878

8. AGE: Years	Months	Days	If less than one day
70	8	27	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name Daniel Fisher
13. Birthplace MD

MOTHER
14. Maiden Name Bertha E Stall
15. Birthplace MD

16 (a) Informant Daniel Fisher III
(b) Address 1006 Hemet Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)
(c) Cemetery or crematory Westview
Location Baltimore MD

18 (a) Funeral director Wilson & Son
(b) Address 1217 E Pratt St

19 (a) DEC 28 1948 (Date rec'd by Registrar) (b) Interment for Williamsport, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948, at 2:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14, 1948 to Dec 26, 1948, and that I last saw h/~~is~~ alive on Dec. 26 1948.

Immediate cause of death	Duration
ACUTE CORONARY THROMBOSIS	
Due to ARTERIA SCLEROTIC CARDIO VASCULAR DISEASE	
Due to	
Other Conditions ARTERIOSCLEROSIS GENERALIZED	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker, Jr. M. D.
Address St. Joseph's Hospital Date signed 12-26-48

VS. 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G698857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Lexington St.
(c) Hospital or institution: Aged Women's-Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Anna Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife George A Wallace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3-1865

8. AGE: Years 83 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Greble
13. Birthplace

MOTHER
14. Maiden Name Anna Kramer
15. Birthplace

16 (a) Informant L. H. Reap
(b) Address 1400 N. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Ave.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

19 (a) DEC 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1948, at 5.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948, to Dec 26 1948 and that I last saw h alive on Dec 26 1948.

Immediate cause of death: Cardio-Respiratory Failure — Duration

Due to Cerebral Hemorrhage

Due to Arteriosclerosis Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howland Edward Day M.D.

Address 4-E-33rd St -18 Date signed Dec 27/48

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 66858

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Orchard Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. Cliff Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE G. LITCHFIELD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sophia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1893

8. AGE: Years	Months	Days	If less than one day
55	7	19	hr. min.

9. Birthplace Hagerstown, Md. (Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business

FATHER
12. Name Samuel Litchfield
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Amrein
15. Birthplace Balto. Md.

16 (a) Informant Margaret Litchfield
(b) Address 2905 Lomse Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
Address 1217 St. Paul St.

19 (a) DEC 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1948, at 5:42PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed 12/27/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

69859 ✓ X 669869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Orchard Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME CHRISTAIN G. HOPP

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary E.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1866

8. AGE: Years 82 | Months 4 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business "

FATHER
12. Name Unknown
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto. Md.

16 (a) Informan: Joseph C. Hopp
(b) Address Orchard Beach, Md.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/29/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Carmel
Location Balto Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul, St.

19 (a) DEC 28 1948 (Date rec'd by ~~Registrar~~) (Registrar) for Williams H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948, at 4.55p M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to .....

Other Conditions Inguinal hernia.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed December 27, 1948

VS 151

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

69890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 69890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor Aves.
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town White Marsh (If outside city or town limits, write RURAL and give town)
(d) Street No. Philadelphia & Silver Spring Rds. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE W. SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 21st, 1884

8. AGE: Years	Months	Days	If less than one day
64	9	6	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation Truck Farmer
11. Industry or business

FATHER
12. Name Jacob Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Lucetta Buddmaier
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Henry Smith
(b) Address Philadelphia & Silver Spring Rds.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran
Location Stemmers Run

18 (a) Funeral director Lassahn Funeral Home.
(b) Address 7501 Belair Rd.

DEC 28 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Dec, 1948, at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1948 to Dec 27 1948, and that I last saw h/M alive on Dec 27 1948.

Immediate cause of death	Duration
Cerebral Vascular Accident	
Due to	
Due to	
Other Conditions Bronchial asthma (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert C. Herrmann M. D.
Address WBG.H. Date signed 12-27-48

VS 153

Physicians: please write the causes of death clearly and legibly.

G69891

Spec.—6-9-19—H. P. Co.—1000 Blks.

G69891

HEALTH DEPARTMENT—CITY OF BALTIMORE

95c

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (a) No. 1411 Argyle Ave St.: Ward)

2-FULL NAME Sallie Matthews 14-6

(a) RESIDENCE. No. 1411 argyle ave. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of James Johnson Sr

6 DATE OF BIRTH (month, day, and year): Mar. 20, 1883

7 AGE — Years: 65 — Months: 9 — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond. Va

PARENTS

10 NAME OF FATHER: James Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mrs Ethel R. Smith
(Address) 2538 Madison ave

15 Filed DEC 28 1948 19 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26, 1948

17 I HEREBY CERTIFY, That I attended deceased from Nov 8-48. 19 to Dec 26-48. 19

that I last saw her alive on Dec 24-48. 19

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chron. Cardiac disease

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. H. Cardozo Jr M. D.

19 (Address) 1524 Whitelock ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arbutus Mem. Park — DATE OF BURIAL: 12/28 1948

20 UNDERTAKER: Charles P. Law — ADDRESS: 802 Madison Ave

NOTE—Very important. See instructions on back of certificates.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. 66892

66892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: 3-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs.) mos. or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 121 W. Hamburg St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ballast
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/18/1855

8. AGE: Years 93 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Bard Brown
13. Birthplace md

MOTHER
14. Maiden Name Simmons
15. Birthplace

16 (a) Informant Harvey W Brown
(b) Address 121 W Monlgomery St

17 (a) Burial (b) Date thereof 12/29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Church Yd
Location Chester Md

18 (a) Funeral director Isaiah L. Brown Sr
(b) Address 1062 W Monlgomery St

19 (a) DEC 28 1948 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1948, at 9 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1948, to Dec 26 1948, and that I last saw h /m alive on Dec 26 1948.

Immediate cause of death	Duration
(a) Uremia	
Due to (b) Dehydration	
Due to (c) Renal insufficiency	
Other Conditions post operative Strangulated Hernia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank E Blumbach M. D.
Address University Hosp Date signed 12/46

VS 159

133B

Keeping of properly important. Physicians: please write the causes of death clearly and legibly.

6698 93

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

837

Registered No. 6698 93

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 S. Kenwood Ave
(c) Hospital or institution: Home 404
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 S. Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Apolonia Oles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Joseph Oles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22 1882

8. AGE: Years	Months	Days	If less than one day
66	11	3	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Chojnacki

13. Birthplace Poland

MOTHER 14. Maiden Name Ratajczak

15. Birthplace Poland

16 (a) Informant Thomas Oles

(b) Address 1114 S Kenwood ave

17 (a) Burial (b) Date thereof Dec 30 48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Stanislaus

Location Dundalk Ave

18 (a) Funeral director John J. Duda

(b) Address 2826 Hudson St.

19 (a) Dec 28 1948 Huntington Williams, M.D.
(Date) (Filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1948, at 4:7 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1948, to Dec. 25 1948, and that I last saw h alive on Dec. 25 1948.

Immediate cause of death Left Hemiplegia — Duration Oct 7-48
Right Hemiplegia — Dec 20-48

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Andrew Thurstowski M. D.

Address 2574 Eastern Ave. Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1208 N. Curley Rd

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. 669849

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 N. Curley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 N. Curley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E. Dungan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Wm. L. Dungan
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May-10-1885

8. AGE: Years	Months	Days	If less than one day
63	7	18	hr. min.

9. Birthplace Philadelphia Pa. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Solomon Cordingly
13. Birthplace England

MOTHER
14. Maiden Name Jane Jonson
15 Birthplace England

16 (a) Informant William L. Dungan
(b) Address 1208 N. Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Magnolia Cem. Location Jacony-Phila. Pa

18 (a) Funeral director John C. Melling Inc
(b) Address 2430 E. Oliver St

19 (a) 12/28/48 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28-1948, at 6 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1935 to 12-27- 1948 and that I last saw her alive on 12-27- 1948

Immediate cause of death: Cerebral Apoplexy — Duration: 4 days
Due to: Generalised arteriosclerosis — ?
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Melton C. Lacy M. D.
Address 2117 Belair Rd Date signed 12-28-48

VS 150

669895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 669895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4100 Belle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 10
(e) Length of stay in Baltimore (yrs., mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4100 Belle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Armistead Crosbie

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. 215-05-0718

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ada Crosbie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-26-1880

8. AGE: Years	Months	Days	If less than one day
68	5	29	hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Crosbie
13. Birthplace England

MOTHER
14. Maiden Name Emma Armistead
15 Birthplace England

16 (a) Informant Ada Crosbie
(b) Address 4100 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem
Location Baltimore Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 DEC 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1948 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1930 to Dec 24 1948 and that I last saw him alive on Dec 24 1948

Immediate cause of death	Duration
Coronary Thrombosis	1 yr 9 mos
Due to	
Due to Arthritis	4 mos
Other Conditions Low Blood Pressure (Include pregnancy within 3 months of death)	

Date of operation X
Major findings of operation: X
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence at M
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X While at work?
(Specify type of place)
(e) Means of injury X

23. Signature A. E. Hearn M.D.
Address 790 Cleveland Ave

X 12/28/48

VS 150

669896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

669896 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 4028 Pennington Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 5 6 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4028 Pennington Ave (If rural give location)
(e) Citizen of foreign country? XXXXXXXX (Yes or No)
If yes, name country

3 (a) FULL NAME Magdalina Tolodziecki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John Tolodziecki
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House work at home
11. Industry or business

FATHER
12. Name Casimir Kolodziejski
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15 Birthplace Poland

16 (a) Informant Agnes Jollie
(b) Address 4028 Pennington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross A.A.CO.
Location Baltimore

18 (a) Funeral director Fred W. Ozarzuta
(b) Address 1930 Eastern Ave.

19 (a) 12/28/48 (Date rec'd by registrar) Huntington Maryland, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1948, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 19 48 to Dec 26 19 48.
and that I last saw her alive on Dec 26 19 48.

Immediate cause of death: Cerebral hemorrhage — Duration
Due to
Due to Hypertensive cardio
Other Conditions Stomach ulcer. Chronic arthritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Baltopeas Ave Date signed 12/27/48

VS 193

830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69837

(Correct age is especially important. Physicians: please write the causes of death clearly and legibly. This information should be carefully supplied.)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St.
(c) Hospital or institution: Fayette Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-01
(e) Length of stay in Baltimore (yrs., mos., or days) 2-01

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 S. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Anyszek

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Anyszek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Anyszek
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15 Birthplace Poland

16 (a) Informant Mary Anyszek
(b) Address 414 S. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30/48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave.

19 (a) 12/28/48 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1948 to Dec 27 1948 and that I last saw h[illegible] alive on Dec 27 1948.

Immediate cause of death	Duration
Acute Cardiac dilatation	20 hrs
Due to Hypertensive Cardiovascular disease	7 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Henry Steinmann M. D.
Address 75 3 W Fayette St Date signed Dec 28 1948

VS 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. 16898

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 828 W. 36th Street
(c) Hospital or institution: 13-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 W. 36th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Irma Ellen Puller

3 (b) If veteran, name war ——

3 (c) Social Security Account No. ——

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Gordon L. Puller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1904

8. AGE: Years	Months	Days	If less than one day
44	3	10	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William H. Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Perkins
15. Birthplace Maryland

16 (a) Informant Gordon L. Puller
(b) Address 828 W. 36th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co., Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) 12/30/48 (Date rec'd by registrar) (b) Huntington Wilson, Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1948, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1948 to Dec 27 1948, and that I last saw her alive on Dec 25 1948.

Immediate cause of death Cancer of pancreas and metastasis

Due to General Carcinomatosis

Due to Carcinoma of uterus.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation March 1948

Major findings of operation: Adherent Cancer of uterus and

of autopsy: metastases.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 3429 Clanton Rd. Date signed Dec 27 48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

663899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 663899

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 W. 33rd Street
(c) Hospital or institution: 13-05
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 W. 33rd Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Emory Wheat

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 705-03-6339

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Ruth B. Wheat
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1898

8. AGE: Years	Months	Days	If less than one day
50 49	8	25	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Electrical Construction

11. Industry or business Baltimore & Ohio Railroad

FATHER
12. Name Elijah M. Wheat
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary O. Wink
15. Birthplace Maryland

16 (a) Informant Mrs. Mary O. Wheat
(b) Address 829 W. 33rd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) 12/28/48 (Date rec'd by Registrar) Edington Williams, M.D.

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH December 25, 1948, at 4.45 M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Heart Disease

Due to

Other Conditions Fracture Right Ankle

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 12-20-48 at 1:45 ? A. M.
(b) Where did injury occur 3302 Keswick Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell from tree to floor

23. Signature Robert B. Mcadden M.D. Medical Examiner.
Date signed 12-23-48

VS 181

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

669900 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5310 Cordelia Ave
(c) Hospital or institution:
12-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5310 Cordelia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phoebe R. Stollenmyer

3 (b) If veteran, name war	3 (c) Social Security Account No.
	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	W.

6 (b) Name of husband or wife Harvey S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 1, 1879

8. AGE: Years	Months	Days	If less than one day
69	5	26	hr. min.

9. Birthplace Brandenburg, Maryland.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Aaron Holt.
13. Birthplace Mass.

MOTHER
14. Maiden Name Delia Frifogel
15 Birthplace Md.

16 (a) Informant Mrs. Maxine Dorker
(b) Address 5310 Cordelia Ave

17 (a) Burial (b) Date thereof 12-28-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore Maryland

18 (a) Funeral director Harry Baker
(b) Address 5005 Park Heights Ave

19 (a) 12-27-48 Lutitia for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1948, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1948. to 12/26 1948.
and that I last saw h alive on 12/26 1948.

Immediate cause of death	Duration
Coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Russell M. D.
Address 3902 Broadway Date signed 12/27/48

VS 153

G69901 B.C 48-23278 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 104a

Registered No. G69901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 Thames Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VANCE EDWARD (JUSTICE) JUSTUS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 23, 1948

8. AGE: Years	Months	Days	If less than one day
0	2	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Theodore Justus
13. Birthplace Hurley, Va.

MOTHER
14. Maiden Name Wanda Madge Wolford
15. Birthplace Woodman, Kentucky

16 (a) Informant Mr. Theodore Justus
(b) Address 1643 Thames Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery or crematory Wolford Grave Yard
Location Blackey, Va. George A Weber

18 (a) Funeral director GEORGE A. WEBER
(b) Address 705 South Ann Street

19 (a) DEC 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1948, at 10:35AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Upper respiratory infection
Status thymico lymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/27/48

VS 151

69902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. 69902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 Homestead St.
(c) Hospital or institution: 9-05
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Homestead St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK DOUGLAS KIRK

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Sadie Lee Kirk
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 1, 1876
8. AGE: Years 72 | Months 3 | Days 25 | If less than one day hr. min.
9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business

FATHER
12. Name Franklin Pierce Kirk
13. Birthplace Scotland

MOTHER
14. Maiden Name Frances Smith
15. Birthplace Warwick Co., Va.

16 (a) Informant Mr. Amos D. Kirk
(b) Address 1308 Homestead St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery or crematory Ft. Lincoln Cem. Wash., D. C.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 12/28/48 (Date rec'd by registrar) (b) Tuttington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1948, at 5:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948 to Dec 26 1948 and that I last saw h alive on Dec 16 1948.

Immediate cause of death	Duration
Carcinoma Lung	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank S Kinzer M. D.
Address 1780 Harford Ave Date signed 12-27-48

VS 150

G69903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1620

Registered No. G69903

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4319 Garrison Blvd.
(c) Hospital or institution: 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4319 Garrison Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALBERT LOUIS BANGS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Carrie Jane Bangs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1863

8. AGE: Years 85 | Months 2 | Days 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: retired Fruit Dealer
11. Industry or business

FATHER
12. Name: John R. Bangs
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Ellen Rebecca Gerns
15. Birthplace: Pa.

16 (a) Informant: Mrs. Carrie J. Bangs
(b) Address: 4319 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) 12/28/48 (Date rec'd by registrar) Beatrice Fox Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1948 at 11:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1948 to Dec 25 1948 and that I last saw him alive on Dec 24 1948.

Immediate cause of death: Coronary Thrombosis — Duration: 3 min

Due to

Due to

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation: X

Major findings of operation: X

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence X at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X (Specify type of place) While at work?
(e) Means of injury X

23. Signature A. E. Hearn M. D.
Address 4304 Garrison Blvd Date signed 12/29/48

VS 193

669904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1B

669904 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 115 Overhill Rd.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-11
(e) Length of stay in Baltimore (yrs., mos., or days) 27-11

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Overhill Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE MAX SUWALL

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Katherine Rose Suwall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1865

8. AGE: Years	Months	Days	If less than one day
83	1	14	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Florist
11. Industry or business Self

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15 Birthplace

16 (a) Informant Mr. Alex Suwall
(b) Address 3 E. Read St.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Maus.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 12/28/48 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1948, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1946 to Dec 26 1948, and that I last saw him alive on Dec 24 1948.

Immediate cause of death Chronic Hypolandism — Duration

Due to generalized arteriosclerosis

Due to

Other Conditions Carcinoma of the prostate
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Acute retention. Adenomatous enlarged prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Howard Stinson Jr. M.D.
Address 18 E. Eager St Date signed 12/27/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69905

BALTIMORE CITY HEALTH DEPARTMENT ✓ G69905

CERTIFICATE OF DEATH 131a

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3405 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-0b
(e) Length of stay in Baltimore (yrs., mos., or days) 15-0b

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3405 Walbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARTIN JOYCE CHADWELL

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	216-03-8687	male	white	married

6 (b) Name of husband or wife Grace M. Chadwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 27, 1883

8. AGE: Years	Months	Days	If less than one day
65	7	28	hr. min.

9. Birthplace Norfolk Co., Va. (Town, county, and state)
10. Usual Occupation Treasurer
11. Industry or business Fresch-Chadwell Co.

FATHER
12. Name Henry Clay Chadwell
13. Birthplace Aquia Creek, Va.

MOTHER
14. Maiden Name Mary R. Nash
15 Birthplace Norfolk Co., Va.

16 (a) Informant Mrs. Grace M. Chadwell
(b) Address 3405 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 12-27-48 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1948, at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947 to Dec 25, 1948 and that I last saw him alive on Dec 25, 1948.

Immediate cause of death	Duration
Pulmonary embolism	
Due to Chronic heart disease with congestive failure	2 yrs
Due to Hypertensive heart disease	2-3 yrs
Other Conditions Chronic glomerulo-nephritis	2 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Randolph K. Spitzberg M.D.
Address 5610 Deerwood Rd Date signed 27 Dec 48

VS 150

Spitzberg 937

669906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 669906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 E. 41-5t.
(c) Hospital or institution: 9-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 92 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 E. 41-5t. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Virginia Farley

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife Chas. F. Farley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1854

8. AGE: Years	Months	Days	If less than one day
94 92	4	11	hr. min.

9. Birthplace Baltimore md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George Richard McCulloh
13. Birthplace Maryland.

MOTHER
14. Maiden Name Elizabeth Leighton
15. Birthplace Maryland

16 (a) Informant K. K. Falkenstein
(b) Address 504 E. 41-5t.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) 12/29/48 (Date rec'd by registrar) (b) Thomas J. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1948, at 3:19 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1947 to Dec. 26 1948, and that I last saw h[illegible] alive on Dec. 26 1948.

Immediate cause of death	Duration
Chr. Myocarditis	1940
Due to	
Due to Chr. Interstitial nephritis	1940
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Brown
Address 1663 W. North Ave Date signed 12-29-48 M. D.

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68907

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

99

Registered No. 68907

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 27-03
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10da
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4813 Harford Road (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mary Griffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Patrick Griffin (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1861

8. AGE: Years	Months	Days	If less than one day
87	9	10	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER 12. Name John Shaughnessy
13. Birthplace Ireland

MOTHER 14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Mary Cumpheny
(b) Address 4813 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director L. D. Luck
(b) Address 5305 Harford Rd.

19 (a) DEC 30 1948 (Date rec'd by registrar) (b) Remington & Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1948, at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Dec 1948 to 27 Dec 1948 and that I last saw her alive on 27 Dec 1948

Immediate cause of death Cardiac Failure — Duration 9 hours

Due to ?Mesenteric Hemorrhage — 9 hours

Due to Auricular Fibrillation — over 2 mos.

Other Conditions Rheumatoid Arthritis

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Ferrie M. D.

Address Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

669908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. 669908

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5903 Wakehurst Way
(c) Hospital or institution:
27-08
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5903 Wakehurst Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eduard Thau,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret Thau
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1873

8. AGE: Years	Months	Days	If less than one day
75	4	19	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Karl Thau
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Margaret Thau
(b) Address 5903 Wakehurst Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) 12/28/48 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1948 to Dec 25 1948 and that I last saw h.i.m alive on Dec 25 1948.

Immediate cause of death Carcinoma of stomach with metastasis to lungs & liver.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 5217 Harford Rd Date signed 12-29-48

V S 150

X

669909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

669909 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 W. Madison Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 Myland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATIE CHASE TINSLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1886

8. AGE: Years 62 | Months 8 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Henry Chase
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katie Sampson
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Minnie Chase
(b) Address 808 Tyson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) 12/29/48 (Date rec'd by registrar) Tuntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1948, at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1944 to 12/25 1948 and that I last saw h[illegible] alive on 12/25 1948

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2134 [illegible] Date signed 12/29

2129 DRUID HILL AVE.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 130

69910 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

✓ 69910 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5203 Denmore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HUDSON ARMSTEAD WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Agnes Mamie White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 6, 1909

8. AGE: Years	Months	Days	If less than one day
39	3	19	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)

10. Usual Occupation Dairyman

11. Industry or business

FATHER
12. Name Humphrey White
13. Birthplace Kilmarnock, Virginia

MOTHER
14. Maiden Name Estelle B. Lee
15. Birthplace Virginia

16 (a) Informant Mrs. Agnes M. White
(b) Address 5203 Denmore Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof December 29, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Luke's,
Location Reisterstown, Md.

18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Druid Hill Avenue

19 (a) 12/28/48 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1948, at 11:22 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Reyler M.D.
Medical Examiner.
Date signed December 27, 1948

VS 151

Please write as legibly as possible. Physicians: please write the causes of death clearly and legibly.

G6911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G6911 Registered No.

Physicians: please write the causes of death clearly and legibly. Any person who wilfully makes any false statement in this certificate or who wilfully conceals any material information relating thereto or who wilfully supplies false information intended to be used in determining the age at death of the deceased, or who wilfully attempts any of the above, is guilty of a misdemeanor and subject to the penalties prescribed by law. Any error in the date of birth previously filed with the Local Registrar should be corrected before burial. Please report any discrepancy in the age at once to the Local Registrar.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 532 N. Carrollton Ave.
(c) Hospital or institution: (If not in hospital or institution, give residence)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 532 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA PADGETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 10, 1885

8. AGE: Years	Months	Days	If less than one day
63	0	16	hr. min.

9. Birthplace Ritter, S.C.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Stephen Jones
13. Birthplace Ritter, S.C.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Jannie Peirson
(b) Address 532 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery or crematory Ritter, S.C.
Location Family lot

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

DEC 28 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948 at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23 1948 to Dec. 26 1948. and that I last saw her alive on Dec. 26 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Hypertensive Car. Vas. Dis.	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George McDonald M.D.
Address 344 N. Carey St. Date signed 12/27/48

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6912

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

167

Registered No. 6912

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BOOKER T. ROSCOE

3 (b) If veteran, name war

3 (c) Social Security Account No. 228-126-196

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1948 1912

8. AGE: Years	Months	Days	If less than one day
36	5	20	hr. min.

9. Birthplace Windsor, N.C.
(Town, county, and state)

10. Usual Occupation Sparrows Point Steel Worker
11. Industry or business

FATHER
12. Name Edward Roscoe
13. Birthplace Windsor, N.C.

MOTHER
14. Maiden Name Helen Hargott
15. Birthplace Windsor, N.C.

16 (a) Informant: Mrs. Mary E. Roscoe
(b) Address 1710 Madison Ave.

17 (a) Burial (b) Date thereof Dec. 28 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Berkeley, W Va

18 (a) Funeral director Wm. Ludwig H. Hyllard
(b) Address 1631 Druid Hill Ave.

DEC 28 1948

19 (a) (b) Registrar for Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24, 1948 19 , at 12:40 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Edmund J Hunt

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 14-0
(a) Date of injury Dec. 25, 48 12:30 A. M.
(b) Where did injury occur? 1713 Madison Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp Instrument

23. Signature Emil Kruger M.D.
Medical Examiner.
Date signed 12/28/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

669933 (669933) Registered No. 93E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 581 Laurens Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4-0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 581 Laurens Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN A. JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10, 1878

8. AGE: Years	Months	Days	If less than one day
70	2	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Nathan Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Adline Thomas
15. Birthplace Maryland

16 (a) Informant Mrs. Sarah C. Pillous
(b) Address 419 Orchard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director MARS. FRANCES A. HEMSLEY
(b) Address 578 W. Biddle Street

19 (a) 12/28/48 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1948, at 2:30 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion Heart Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rogers M.D.
Medical Examiner
Date signed 12-27-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G69914 BALTIMORE CITY HEALTH DEPARTMENT G69914

Registered No.

CERTIFICATE OF DEATH 49a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1718 N. Payson St.
(c) Hospital or institution: 15.02
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KATHERINE N. POWELL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Braxton D. Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1889

8. AGE: Years	Months	Days	If less than one day
59	10	10	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward Nickens
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret Crocker
15. Birthplace Va;

16 (a) Informant Mr. Braxton D. Powell
(b) Address 1718 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 528 W. Biddle St.

19 (a) 12/18/48 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Dec. 25, 1948 at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1947 to 12/25 1948 and that I last saw her alive on 12/25 1948

Immediate cause of death	Duration
papillary cystadenoma right ovary	
Due to (malignant degeneration)	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature RAYNER BROWNE, M. D.
Address 1500 EAST MADISON ST. BALTIMORE 5, MD. Date signed 12/27/48

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

669915 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Myna Teague Richards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1898

8. AGE: Years	Months	Days	If less than one day
50	9	11	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Minder Teatue
13. Birthplace S. C.

MOTHER
14. Maiden Name Hattie Holland
15. Birthplace S. C.

16 (a) Informant Mrs Essie Fortune
(b) Address 1643 - 10th St-Wash.D. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)
(c) Cemetery or crematory Lincoln Park
Location Washington, D. C.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) 12/28/48 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Dec 23, 1948, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22/48 to 19 . and that I last saw h[illegible] alive on 12/22/48.

Immediate cause of death Acute Carcinoma

Due to of the Fundus Uterus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Several Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Barksdale M. D.
Address 576 N. Carey St. Date signed 12/29/48

VS 150

Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 M

Registered No. 669916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 S. Payson st
(c) Hospital or institution: — — — 20-03
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 S. Payson St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country —

3 (a) FULL NAME Conrad D. Zimmermann

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Katherine A.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 14-1866

8. AGE: Years	Months	Days	If less than one day
82	5	13	hr. min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation Retired - Watchman
11. Industry or business Bald Transit Co.

FATHER
12. Name Unknown.
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany.

16 (a) Informant Mrs. Wilhelmina Zimmermann
(b) Address 3410 Gardenia ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1512 Hollins St

19 (a) DEC 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1948, at 9 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1948 to Dec. 27 1948 and that I last saw him alive on Dec. 27 1948.

Immediate cause of death Metastatic Carcinoma — Duration 2 mo.
Due to Carcinoma of S. I Tract — 1 yr.
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Solomon Friedman M. D.
Address 7424 Eutaw Place Date signed 12/28/48

VS 153

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95

Registered No. G69[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 Collett Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15-0 ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Collett Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD L. GREENE

3 (b) If veteran, name war World War No. 2

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/30/1907

8. AGE: Years 41 | Months 7 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Thomas Greene
13. Birthplace Maryland

MOTHER
14. Maiden Name Matilda [illegible] Brooks
15. Birthplace 1507 N. Payson St.

16 (a) Informant Matilda Greene
(b) Address 1507 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Maryland

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman St.

19 (a) 12/28/48 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948, at 6:30PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Rheumatic Heart Disease

Due to

Other Conditions Alcoholism
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/27/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

669918 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 707 S. Port Street
(c) Hospital or institution: 1-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 S. Port Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MAGDALENA MARSZALKIEWICZ

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife marshalkiewicz
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 1866

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name	William Walkowiak
13. Birthplace	Poland
MOTHER 14. Maiden Name	unknown
15. Birthplace	Poland

16 (a) Informant Mrs Selma Zurek
(b) Address 707 S. Port Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore Co. Md.
18 (a) Funeral director John M. Welsh
(b) Address 401 S. Chester Street
19 (a) DEC 28 1948 (Date rec'd by registrar) (b) Interior Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1948 at 7- AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 13 1948 to Dec 25 1948, and that I last saw h[illegible] alive on Dec 23 1948.

Immediate cause of death Carcinoma of right femur.

	Duration
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation ~~Dec~~ 1948
Major findings of operation: Carcinoma
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Thompson M. D.
Address 704 E. Biddle St. Date signed 12-29-48

VS 8

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G69919 G69919 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 S WOLFE ST.
(c) Hospital or institution: 201
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 S WOLFE ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MICHAEL SUSZYNA.

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 215-03-0670

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 29 1889

8. AGE: Years	Months	Days	If less than one day
69	3	26	hr. min.

9. Birthplace SIFANIC POLAND. (Town, county, and state)

10. Usual Occupation

11. Industry or business LABOR

FATHER 12. Name WAWRZYNOI SOSZYNA.

13. Birthplace POLAND.

MOTHER 14. Maiden Name MARIANNA SZUMILA

15 Birthplace POLAND.

16 (a) Informant FRANCIS KOZLOWSKI

(b) Address 7714 FAIRGREEN RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 29 48 (month) (day) (year)

(c) Cemetery or crematory HOLY ROSARY

Location GERMAN HILL RD.

18 (a) Funeral director DIPPEL BROTHERS

(b) Address 1800 E LOMBARD ST

19 DEC 28 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 25 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1948, to Dec. 25 1948, and that I last saw him alive on Dec 25 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew Turnbrook M. D.

Address 725 E Eager St. Date signed

VS 150

Coverage in capacity indicated: physicians: please write the causes of death clearly and legibly.

Medical Examiner Case ✓

Released to Hosp. 181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66920

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
18-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 W. Fayette st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Junior Trucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-13-44

8. AGE: Years	Months	Days	If less than one day
4	2	10	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Trucker

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 '48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Balto Co Md

18 (a) Funeral director Mrs Roff A. Ellison Dept

(b) Address W 29th N. Carlton St

19 (a) 12/20/48 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1948, at 8 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1948 to 12/23 1948 and that I last saw him alive on 12/23 1948

Immediate cause of death Shock due to

* Burns

Due to

Due to

Other Conditions Hemophilia

(Include pregnancy within three months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

CAUSE OF DEATH APPROVED BY

Edward J. Boyle M.D.

CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 18/1

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 12/23 at 4 P.M.

(c) Where did injury occur? Balto. Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? (Clothes became ignited--coal stove)

(e) Means of injury Burns

23. Signature Eugene O. Goodale M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 12/26/48

VS 150 To be approv. by Med-Exam

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

✓ Registered No. 669921

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 N. Schroeder (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	married

6 (b) Name of husband or wife Lessie MacHenry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22, 1907

8. AGE: Years	Months	Days	If less than one day
41	1	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name not known
13. Birthplace

MOTHER
14. Maiden Name not known
15. Birthplace

16 (a) Informant Rev. Helena Laurence
(b) Address 418 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director G. Heletfield
(b) Address 916 Lemmon Street

19 (a) 12/28/48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1948, at 4:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1948, to Dec 27 1948, and that I last saw him alive on Dec 27 1948.

Immediate cause of death	Duration
Heart Block.	
Due to Rheumatic Myocarditis	unknown
Due to	
Other Conditions mitral & aortic stenosis	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Stull M. D.
Address Mercy Hospital Date signed Dec 27, 1948

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 193

X

659222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 669222

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd.
(c) Hospital or institution:
Colonial Nursing Home 26-04
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Brenner

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	no	male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3 1877

8. AGE: Years	Months	Days	If less than one day
71	1	22	hr. min.

9. Birthplace Breman Germany
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Mary Moran
(b) Address 3525 E. Fayette St.

17 (a) Burial (b) Date thereof Dec. 28/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location 112 Bonsl Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 322 S. High St.

19 (a) 12/28/48 (b) Huntington Williams Md.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25/48 19 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8/48 19 to 12/25/48 19.
and that I last saw h[illegible] alive on 12/24/48 19

Immediate cause of death Myocardial Infarction — Duration [illegible] hours

Due to Bronchopneumonia — 1 week

Due to Arteriosclerosis

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen S. Moran

Address 3525 E. Fayette St. Date signed 12/28/48

VS 150

G69923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G69923

Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Information must be correctly supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address **Monument & Rutland St.**
(c) Hospital or institution: **Sinai Hospital** 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) **28 Yrs.**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Md** (b) County
(c) City or town **Baltimore** (If outside city or town limits, write RURAL and give town)
(d) Street No. **4108 Frankfort Ave** (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME **Luigi** Joseph CASSERI CASSERI ✓

3 (b) If veteran, name war **no**

3 (c) Social Security Account No. **219-03-0427**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	**White**	**Married**

6 (b) Name of husband or wife **Argentina Casseri**
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) **July 2 1883**

8. AGE: Years	Months	Days	If less than one day
65	**5**	**24**	hr. min.

9. Birthplace **Roccagorga Roma Italy** (Town, county, and state)
10. Usual Occupation **Watchman**
11. Industry or business **Bethlehem Steel Corp.**

FATHER
12. Name **Vinceslao Casseri**
13. Birthplace **Italy**

MOTHER
14. Maiden Name **Adelaide Celani**
15. Birthplace **Italy**

16 (a) Informant **Anthony Casseri (Son)**
(b) Address **4108 Frankfort Ave**

17 (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Dec. 30 1948** (month) (day) (year)
(c) Cemetery or crematory **Holy Redeemer Cem.**
Location **Belair Rd. Baltimore Md.**

18 (a) Funeral director **Frank Della Rocca**
(b) Address **322 S. High St.**

19 (a) DEC 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **12-26** 1948, at **10** M

21. I certify that death occurred on the date above stated; that I attended deceased from **12-24** 1948 to **12-26** 1948, and that I last saw h/M alive on **12-26** 1948.

Immediate cause of death	Duration
Bilateral Bronchopneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature **Jerome Gaber** M. D.
Address **Sinai Hosp** Date signed **12-26-48**

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. 669924

669924

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital E-05
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (WILLIS SIMPSON) WILLIE SAMPSON (djm)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
47 (DJM)			hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Simpson
13. Birthplace South Carolina

MOTHER
14. Maiden Name May Thomas
15. Birthplace South Carolina

16 (a) Informant: May Annie Simpson
(b) Address 523 S. Sharp Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director Isaac L Bowman Son
(b) Address 1840 Mount Street

19 (a) DEC 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1948, at 9:40 AM

21. I certify that I took charge of the remains described above, held an Inspection and Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/23/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

CERTIFICATE CORRECTED 2-16-49

669925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. 669925

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 das.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, Md (b) County Carroll County
(c) City or town Linebero
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: RALPH EDWIN CRAMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, (1896) 1912

8. AGE: Years	Months	Days	If less than one day
(42) 36	11	13	hr. min.

9. Birthplace Lancaster Co., Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Oscar Cramer
13. Birthplace Lancaster Co. Pa.

MOTHER
14. Maiden Name Cora Wise
15. Birthplace York Co.

16 (a) Informant Oscar Cramer
(b) Address Lineboro, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/28/48 (month) (day) (year)
(c) Cemetery or crematory Windsor
Location Windsor, Pa.

18 (a) Funeral director H. C. Geiple
(b) Address Glen Rock, Pa.

19 DEC 28 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 19 48, at 1:15 A.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull.
Intracranial hemorrhage.
Due to Contusion and laceration of brain.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 23/48 approx. 6:25 A.M. near Pikesville
(b) Where did injury occur? Reisterton Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto into guard rail

23. Signature George G. Merrell M.D.
Medical Examiner.
Date signed 12/28/48

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669926

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

669926 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 20-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 North Fulton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT D. DRISCOLL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1878

8. AGE: Years	Months	Days	If less than one day
70	11	8	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation doctor

11. Industry or business

FATHER
12. Name John J. Driscoll
13. Birthplace South Carolina

MOTHER
14. Maiden Name Ellen Massey
15. Birthplace Richmond, Virginia

16 (a) Informant Mr. Clarence Scarlett
(b) Address 1717 Bolton Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12-30-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John A. Cowan & Son
(b) Address 901 Hollins Street

19 (a) DEC 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1948, at 2.10p M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed December 28, 1948

VS 181

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47

Registered No. 669927

669927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 E. 41" St
(c) Hospital or institution: 9-61
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 E. 41" St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph E. Zeck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Margaret C. Zeck
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr) May 7, 1895

8. AGE: Years	Months	Days	If less than one day
53	7	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name John Zeck
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Margaret C. Zeck
(b) Address 808 E. 41" St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Beloit Rd

18 (a) Funeral director John A. Moran
(b) Address 3600 E. Balt. St.

19 DEC 28 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1948, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1948 to Dec 27 1948 and that I last saw him alive on Dec 26 1948.

Immediate cause of death: Carcinoma of lung — Duration: 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation July, 1948
Major findings of operation:
Carcinoma of lung
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Sawyer M. D.
Address 4808 Harford Rd Date signed 12/28/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

669928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 669928

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2717 Orleans St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-0-0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Widowed

6 (b) Name of husband or wife Valentine King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 30, 1861

8. AGE: Years	Months	Days	If less than one day
86 87	11	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Ehrman
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Virginia Victor
(b) Address 2717 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)
(c) Cemetery or crematory Morland Park
Location Taylor Ave

18 (a) Funeral director John A. Moran
(b) Address 3006 E. Baltimore St.

19 (a) DEC 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1948, at 7.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1947, to Dec. 24 1948, and that I last saw h alive on Dec. 24 1948.

Immediate cause of death	Duration
(a) Fecal Arteriosclerosis	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm J Schmitt M. D.
Address 701 N. Kenwood Ave Date signed 12/29/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G69929

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2549 Lauretta Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BETTY JANE CARBERRY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Donald Carberry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1930

8. AGE: Years	Months	Days	If less than one day
18	9	12	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Typist

11. Industry or business Montgomery Ward Company

FATHER
12. Name Joseph J. Wilsen
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Doris Baker
15. Birthplace Maryland

16 (a) Informan: Joseph J. Wilsen
(b) Address 2549 Lauretta Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director John R. Moran
(b) Address 3000 E. Baltimore St.

19 DEC 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1948, at 11:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 25, 11:25 P.M.
(b) Where did injury occur? 2549 Lauretta Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? At home. While at work?
(d) Means of injury Head in gas range oven, all burners on, unlit.

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12/27/48

VS 151

669950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 472

Registered No. 669950

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 28 days
(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1732 Light St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: WALTER CROSBY LOWERY

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: 220-07-0569

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Pearl Lowery
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): May 19, ?1894

8. AGE: Years	Months	Days	If less than one day
?54	7	5	hr. min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business: Seafarer

FATHER
12. Name: James Lowery
13. Birthplace: Md.

MOTHER
14. Maiden Name: ?
15. Birthplace:

16 (a) Informant: Records
(b) Address: U.S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 29, 1948 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Gen
Location: Baltimore Md.

18 (a) Funeral director: Tyson & Fleming
(b) Address: 1416 Light St Balt 30 Md

19 (a) DEC 28 1948 (Date rec'd by registrar) (b) Lennington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24 1948, at 6:55PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1948 to Dec. 24 1948 and that I last saw him alive on Dec. 24 1948.

Immediate cause of death: Carcinoma of left lung with metastasis — Duration: Unknown

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Clinical Director
Address: M. D. Date signed: 12/27/48

G69931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69931

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-04
(e) Length of stay in Baltimore (yrs., mos., or days) 15-04

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emory N. Peregoy

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mildred Wo. Peregoy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 - 1904

8. AGE: Years	Months	Days	If less than one day
74	11	8	hr. min.

Woodlawn Md.
(Town, county, and state)

10. Usual Occupation Ice Business.
11. Industry or business

FATHER
12. Name John Peregoy
13. Birthplace Woodlawn Md.

MOTHER
14. Maiden Name Julia A. Smith
15. Birthplace Woodlawn Md

16 (a) Informant: Mrs. Mildred Peregoy
(b) Address 2036 W. North Ave

17 (a) Burial (b) Date thereof Dec. 30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Baltimore Md.

18 (a) Funeral director Ingmire Corp. Lyfor
(b) Address 1640 W. North Ave

19 (a) DEC 28 1948 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1948, at 9:54 M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Hypertensive C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12/29/48

VS 151

669932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 669932

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dot
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days) yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Conway St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Nelson

3 (b) If veteran, name war World War #1

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife Rosa Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-17-1897

8. AGE: Years	Months	Days	If less than one day
51 (2mo)	11	19	hr. min.

9. Birthplace Sumter, S.C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business City of Baltimore

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Aaron Johnson
(b) Address 618 W. Conway Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31. 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore City

18 (a) Funeral director Joseph A Bixley
(b) Address 6 W Mt Vernon Pl

19 DEC 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1948 at 6:34 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pelouze M.D.
Medical Examiner.
Date signed 12/26/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

669933
AB-124 334

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

Registered No. 669933

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 546 S. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Epps

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Hattie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17- 1909

8. AGE: Years	Months	Days	If less than one day
39	7	10	hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence Epps
13. Birthplace S.C.

MOTHER
14. Maiden Name Ida Mazone
15. Birthplace S.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1. 1949 (month) (day) (year)
(c) Cemetery or crematory Kingstree S. Carolina
Location Williamsburg County

18 (a) Funeral director Joseph A. Sibley
(b) Address 66 West Lane Street

19 (a) DEC 28 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27- 1948 at 12.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5- 1948 to 12-27- 1948, and that I last saw him alive on 12-27- 1948.

Immediate cause of death — Duration

Due to Pulmt. Tb

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Gaylord Bunton M. D.
Address Baltimore City Date signed 12/27/48

Hosp X

69934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. 69934

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 26-11 Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7hrs.15min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 S. Clinton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: PAUL J. SCHMITT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-7-19

8. AGE: Years	Months	Days	If less than one day
29	5	18	E.M.W. hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Estimater

11. Industry or business Maryland Drydock Corp.

FATHER
12. Name Peter Schmitt
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Mertel
15. Birthplace Germany

16 (a) Informant George Schmitt (Brother)
(b) Address 615 S. Clinton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)
(c) Cemetery ~~pa crematory~~ Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director CHARLES S. ZEILER
(b) Address 901 S. Conkling Street

DEC 28 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1948, at 6:45A.M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of Skull -
Intra Cranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 11-02
(a) Date of injury 12-24-48, at 11:00 P.M.
(b) Where did injury occur? Center & Cathedral Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto & Auto Collision (Passenger)

23. Signature [signature] M.D. Medical Examiner.
Date signed 12-27-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

669935 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 Enfield Road
(c) Hospital or institution:
27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 53 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Enfield Road
(If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country ---------

3 (a) FULL NAME Robert A. McKee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gertrude Mooney
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1895

8. AGE: Years	Months	Days	If less than one day
53	2	12	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Atlas Wiping Cloth Co.

FATHER
12. Name James McFee
13. Birthplace Maryland

MOTHER
14. Maiden Name ------ Bowdle
15. Birthplace Maryland

16 (a) Informant Mrs. Gertrude M. McKee
(b) Address 103 Enfield Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meeks and Son
(b) Address 805 N. Calvert Street

19 DEC 28 1948 (Date rec'd by registrar) (b)

WORLD WAR [illegible] DECEASED
Hunter's Lane Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1948, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940, to Dec 27 1948.
and that I last saw h alive on 19

Immediate cause of death Acute cardiac dilatation — Duration 6 hrs.

Due to Myocarditis

Due to (?)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. H. Maynard M. D.
Address 13 E Eager Date signed 12/29/48

39.36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 93 John F. Forrester

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 437 Freeman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 0 4
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Brooklyn. (If outside city or town limits, write RURAL and give town)
(d) Street No. 437 Freeman. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret P. Forrester

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John F. Forrester
6 (c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) Aug 31, 1874
8. AGE: Years 74 | Months 3 | Days 27 | If less than one day: hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Charles Farr
13. Birthplace Va.

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs John Forrester
(b) Address 437 Freeman St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 31 48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway
18 (a) Funeral director John F. Denny, Inc
(b) Address 715 Light St.
19 (a) DEC 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1948, at 9 02 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 to Dec 28 1948 and that I last saw her alive on Dec 27 1948.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Arteriosclerotic	
Due to Cardiovascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph C. Matchar D.
Address 300 Patapsco Ave. Date signed Dec 28

VS 150

1948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. 66949.57

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 E. Cross St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frieda Elizabeth Schaefer

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Henry

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) January 17, 1881

8. AGE: Years 67 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Frank Brehme
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mr Henry Schaefer
(b) Address 315 E. Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12, 29, 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director John F Henry Inc
(b) Address 715 Light St

19 (a) DEC 29 1948 (Date rec'd by registrar) (b) Interior for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1948, at 2 10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac Failure

Due to Hypertensive Cardio-Vascular Disease

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. Magadden M.D.
Medical Examiner.
Date signed 12-27-48

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

669938 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 N. CHARLES ST. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH STOOP

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23 1864

8. AGE: Years 84 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Cleveland, Ohio (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name John Stoop
13. Birthplace Germany

MOTHER 14. Maiden Name Russ
15. Birthplace Germany

16 (a) Informant Mrs. Jann Walsh
(b) Address Elyria Ohio

17 (a) Burial - Removal - Cremation (Burial, cremation, or removal) proof 12/30/48 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity
Location Avon Ohio

18 (a) Funeral director L. J. Rick
(b) Address 5305 Harford Rd.

19 DEC 29 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28-48 19 , at 5:10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 25, 1948 to Dec. 28, 1948 and that I last saw her alive on Dec 28 1948.

Immediate cause of death	Duration
ACUTE CORONARY Thrombosis.	
Due to ARTERIOSCLEROTIC CARDIOVASCULAR Disease	
Due to ARTERIOSCLEROSIS Generalized.	
Other Conditions ANEMIA.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker, Jr. M.D.
Address St. Joseph's Hospital Date signed 12/28/48

6999.39 Certificate Corrected 1-14-49. 1624 ✓ 6999.39

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 24-03

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 Battery Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD FARRELL

3 (b) If veteran, name war: World War No. II
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife: Esther Farrell
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 10, 1910

8. AGE: Years	Months	Days	If less than one day
38	5	16	____ hr. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Cab Driver
11. Industry or business: Diamond Cab Company

FATHER
12. Name: Edward Farrell
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Mamie ?
15. Birthplace: Baltimore, Maryland

16 (a) Informant: George Marshall
(b) Address: 304 Martingale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director: William Cook, Inc.
(b) Address: St. Paul and Preston Sts.

19 DEC 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948, at 8:40 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, ~~suicide~~ accident ☐, ~~suicide~~ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Hemorrhage due to gunshot wound

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/26/48 at 8:40 P.M.
(b) Where did injury occur? 16 W. Hamburg Street
(c) Did injury occur at home, on farm, industrial place, in public place Home of Mother, Mrs. Mary Marks While at work? No
(d) Means of injury Gun shot wound (1) ~~gunners~~ gun unit.

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12/26/48

X

669940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

669940 Registered No.

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 7-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17days
(e) Length of stay in Baltimore (yrs., mos., or days) 56yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4813 Crowson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. MARY ELIZABETH RIALL

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife: LEVIN W. RIALL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1892

8. AGE: Years 56yr | Months 4 | Days 9 | If less than one day hr. min. 28

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George B. Ogier
13. Birthplace Md.

MOTHER 14. Maiden Name Sarah E. Jewell
15. Birthplace Md.

16 (a) Informant Daughter + Petitioner's sister
(b) Address Same.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Md

18 (a) Funeral director Tillman & Doe
(b) Address 1217 E Fort Ave

19 DEC 29 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1948, at 11:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1948 to Dec 28 1948 and that I last saw h.e.r. alive on 19

Immediate cause of death	Duration
Carcinomatosis	
Due to Carcinoma of Gall Bladder	
Due to Metastatic Carcinoma of lymph nodes	
Other Conditions Biliary obstruction	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III M. D.
Address Date signed

VS 150

6699-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6699-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 15 minutes
(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2412 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: WILLIAM EDWARD WARNER

3 (b) If veteran, name war: WWI

3 (c) Social Security Account No.: 214-18-1580

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lula Sheehan Warner

6 (c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Jan. 14 1900

8. AGE: Years 48 | Months 11 | Days 21 | If less than one day: hr. min.

9. Birthplace: Balto Md.
(Town, county, and state)

10. Usual Occupation: Steam crane operator

11. Industry or business: Bethlehem Steel Works

FATHER
12. Name: John Warner
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Margaret Russell
15. Birthplace: Balto Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) DEC 29 1948 (Date rec'd by registrar) (b) Huntington Williams Mgr. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28 1948 at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1948 to Dec. 28 1948, and that I last saw him alive on Dec. 28 1948.

	Duration
Immediate cause of death: Infarction of myocardium due to arteriosclerotic coronary thrombosis	1 yr.
Due to:	
Due to:	
Other Conditions: Congestive cardiac failure (Include pregnancy within 3 months of death)	1 yr.

Date of operation:
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: [signature] Van Ackeren, Medical Director P.
Address: Medical Officer in Charge Date signed: 12/28/48

VS 150

Medical Examiner's Case

J1- 125066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 66942

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 11-03
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Daley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12 ? 18?

8. AGE: Years	Months	Days	If less than one day
65 ?	10	10	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Martin Daley
13. Birthplace ?

MOTHER
14. Maiden Name Ellan ?
15. Birthplace N. Y.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore Md.

18 (a) Funeral director William Cook Inc
(b) Address 2194 E. Pratt St.

19 (a) DEC 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

To be approved by Medical Examiner

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1948, at 4.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1948, to Dec. 22 1948, and that I last saw h en live on Dec. 22 1948.

Immediate cause of death Bronchopneumonia — Duration Days

CERTIFICATION APPROVED BY
B.A. Merrill M.D.
for: John R. Davis, M.D.
CHIEF OR ASST. MEDICAL EXAMINER

Due to

Due to

Other Conditions fracture, tibia - 9 wks
rectal tumor, ?
(Include pregnancy within three months of death)

Date of operation None

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 11/3
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Oct 29 '48 at 11 AM
(c) Where did injury occur? Balt Balt Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury slipped on rug at home

23. Signature Theodore Groff M. D.
Address Balt City Hosp Date signed 1/2/49

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registration No. 66943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 Eutaw Place
(c) Hospital or institution: 13-0r
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugo Bernstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances Nee Miranda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Kalman Bernstein
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Cecelia Mendel
15. Birthplace Baltimore Md

16 (a) Informant Frances Bernstein
(b) Address 2209 Eutaw Place

17 (a) Burial (b) Date thereof Dec 29, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

DEC 29 1948 (Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1948, at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1948 to Dec. 8 1948.
and that I last saw h[illegible] alive on Dec. 28 1948

Immediate cause of death
Coronary Thrombosis
Due to Myocardial Insufficiency
Due to Generalized Arteriosclerosis
Due to
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 2 days / 10 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Irving Grinker M.D.
Address 1 Mt. Vernon Place Date signed 12/28/48

VS 150

G69944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G69944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2564 Edmondson Ave.,
(c) Hospital or institution: 15.06
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 Braddish Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy L. Holub

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or ~~wife~~ Frank Holub
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 7 1906

8. AGE: Years	Months	Days	If less than one day
42	2		hr. min.

9. Birthplace N. Carolina
(Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name Richard L. Pierce
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Bessie Blanchard
15. Birthplace N. Carolina

16 (a) Informant Mr. Frank Holub
(b) Address 1638 Braddish Ave.,

17 (a) Burial (b) Date thereof 12-29-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.,

19 DEC 29 1948 (Huntington Williams, M.D.)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948, at 4.30 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27-47 19 48 to 12-26 19 48, and that I last saw h. alive on 12-26-48 19

Immediate cause of death: Coronary Occlusion / Myocardial failure - Intestinal
Due to: Carcinoma of stomach
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry S. Lumbl M. D.
Address 2703 Edmondson Date signed 12-27-48

VS 150

669945

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

669945 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 12-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Whitelock St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elsie Pels

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no
4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Walter Pels
6 (c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): 9-12-01
8. AGE: Years 47 | Months 2 4 | Days 16 | If less than one day: hr. min.
9. Birthplace: Md (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business
FATHER 12. Name: Isaac Bachenheimer
13. Birthplace: Germany
MOTHER 14. Maiden Name: Betty Speer
15. Birthplace: Germany
16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Crematory
Location: Balto., Md.
18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.
DEC 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 150

20. DATE OF DEATH: Dec. 28 1948, at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1948 to 12/28 1948 and that I last saw h[illegible] alive on 12/28 1948.

Immediate cause of death: Breast adenocarcinoma with metastases to — Duration: unknown
Due to: left lung, pleura, and thorax, and pericardium
Due to:
Other Conditions: Serocardial effusion, Hydropneumothorax, left
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John G. Bull M. D.
Address: JOHNS HOPKINS HOSPITAL Date signed Dec 28, '48

VS 150

G69946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G69946 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 W. Rogers Ave.
(c) Hospital or institution: 77-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES LEE MERRIKEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Irma R. Merriken
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1871

8. AGE: Years	Months	Days	If less than one day
77	6	11	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business Self

FATHER
12. Name James Thomas Merriken
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Elizabeth Lee
15. Birthplace Baltimore

16 (a) Informant Mr. Risley Ensor
(b) Address 1308 E. Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27th 1948, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1st 1948 to Dec 27th 1948, and that I last saw him alive on Dec. 27th 1948.

Immediate cause of death	Duration
Coronary Thrombosis	Abt 7 days
Myocardial Insufficiency	
Due to Arteriosclerosis	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Hilliard M. D.
Address 1300 E. Mount St. Date signed Dec 28 1948

X

669947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. 669947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1726 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 6

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE MILDRED JOHNSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Edward G. Johnson, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1886

8. AGE: Years	Months	Days	If less than one day
62	10	11	hr. min.

9. Birthplace Rock Hall, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John W. Downey
13. Birthplace Md

MOTHER
14. Maiden Name Hynson
15. Birthplace Md.

16 (a) Informant Mrs. Helen J. Waltz
(b) Address 4207 Granada Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 29 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1948, at 6:35p M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1947 to 12/27 1948 and that I last saw her alive on 12/27 1948.

Immediate cause of death	Duration
Metastatic carcinoma	
Due to Carcinoma of ovary	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Idemuck M. D.
Address 4210 Liberty Hts. Date signed 12/28/48

VS 150

X

669948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

669948 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-09
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Chelsea Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME J. Frank Brown, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Esma A. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1883

8. AGE: Years	Months	Days	If less than one day
65	1	3	hr. min.

9. Birthplace Md (Easton) (City, county, and state)
10. Usual Occupation Clerk
11. Industry or business Baker-Watts Co.

FATHER
12. Name Joseph F. Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Anderson
15 Birthplace Maryland

16 (a) Informant Mrs. Esma A. Brown
(b) Address 3105 Chelsea Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 29 1948 (Date rec'd by registrar) (b) Registrar Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 1948, at 12 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1948 to 12/28 1948, and that I last saw h[illegible] alive on 12/27 1948.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Generalized debility

Due to Carcinoma of lung.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carlos J. Black M. D.
Address Maryland General Hospital Date signed

VS 150

G69949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G69949

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Jenkins Mem. Hosp. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary A. Kelley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1900

8. AGE: Years	Months	Days	If less than one day
48	0	25	hr. min.

9. Birthplace Wilmington, Delaware (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Edw Kelley
13. Birthplace Wilmington, Delaware

MOTHER
14. Maiden Name Mary J. Griffith
15. Birthplace Wilmington, Del

16 (a) Informant Miss Margaret C. Kelley
(b) Address 614 Winans Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/28 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1948, at 12.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9, 1941 to Dec 27 1948, and that I last saw her alive on 12/27 1948.

	Duration
Immediate cause of death: Congestive failure	
Due to: Rheumatic cardio-vascular heart disease	? yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert J. Lurcher, M.D.
Address St. Agnes Hosp. Date signed 12/27/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 193

G69950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G69950

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) .03
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK FONDELHEIT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) April 8, 1864

8. AGE: Years	Months	Days	If less than one day
84	8	18	..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Fondelheit
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Estelle F. Seipes
(b) Address 2011 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29/48 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Maryland

18 (a) Funeral director F. B. Wippert ' Son
(b) Address 1300 EUTAW PLACE..17

19 (a) DEC 29 1948 (b) (Date rec'd by registrar) Funeral for Williamsport MD

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 26 1948, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1947 to Dec 26 1948.
and that I last saw him alive on 12-26 - 1948.

Immediate cause of death Recurrent cerebral hemorrhage — Duration

Due to Adv. arteriosclerosis
Cardio-vascular Disease
advanced

Due to

Other Conditions Residual paralysis
Rt. face tongue typ/atic
(including pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Jacob M. D.
Address 1700 Eutaw Pl. Date signed 12-28-48

VS 153

C649.51

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. C649.51

CERTIFICATE OF DEATH 46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson & Fayette Sts.
(c) Hospital or institution: Bon Secours Hosp. 1904
(d) Length of stay in hospital or inst. (~~yrs.~~, ~~mos.~~, or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Carrie-McNally Carrie McNally

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~
Female	W	Widowed

6 (b) Name of husband or wife Thomas P.
6 (c) If alive, give age ~~84~~ years

7. Birth date of deceased (mo., day, yr.) 7-25-1862

8. AGE: Years	Months	Days	If less than one day
86	5	1	— hr. — min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business At Home

FATHER
12. Name William Nagel
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace Maryland.

16 (a) Informant Mrs. Mattie C. Feick
(b) Address 1824 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 29 Dec 48 (month) (day) (year)
(c) Cemetery or crematory Westcott
Location Baltimore Md.

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1200 Eutaw Pl. 17

19 (a) Dec 29 1948 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1948, at 8:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1948, to 12/26 1948, and that I last saw h~~e~~r alive on 12/25 1948.

Duration
over

Immediate cause of death Cardiac failure
Pulmonary Edema
Due to arteriosclerosis
Due to
Other Conditions Intestinal Obstruction
Intestinal Neoplasm
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Womack M. D.
Address Bon Secours Hosp. Date signed 12/26/48

VS 150

97

6699:2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

6699:2 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2130 W. Mulberry St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2130 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** William C Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary A. Hill
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 10/23/1882

8. AGE: Years	Months	Days	If less than one day
66	2	4	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Woodwork Bro

FATHER
12. Name Walter Hill
13. Birthplace England

MOTHER
14. Maiden Name Sarah A. Hill
15. Birthplace England

16 (a) Informant Mary A. Hill - wife
(b) Address 2130 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 30 Dec 48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md

18 (a) Funeral director F. B. Wehrheit & Son
(b) Address 800 Eutaw Place

DEC 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1948, at 1:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to 12/27 1948, and that I last saw him alive on 12/27 1948.

Impediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Carroll Langdon M. D.
Address 701 N. Payson St. Date signed 12/29/48

VS 152

G699:83 V 83B G699:83

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20-01

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore —
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 N. Monroe St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Phipps

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Estella L. Phipps
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Aug. 5-1869

8. AGE: Years	Months	Days	If less than one day: hr.	min.
79	4	22		

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Henry Phipps
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen Phipps
15. Birthplace Maryland

16 (a) Informant E. E. Phipps Son
(b) Address 4218 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 30 Dec 48 (month) (day) (year)
(c) Cemetery or crematory Loraine Park
Location Woodlawn Md

18 (a) Funeral director P. B. Weyler & Son
(b) Address 3704 Eastern Ave

19 DEC 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1948 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1947 to Dec 27 1948, and that I last saw him alive on Dec 27 1948.

Immediate cause of death: Cerebral Thrombosis right — Duration 3 days
Due to Arteriosclerosis
Due to Prostatectomy and Hypertrophy of Prostate Gland — 5 yrs.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Uhlenhuth Jr
Address 1227 Wash Blvd Date signed 12/29/48

VS 193

6699:54

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

6699:54 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address S 1100 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-04 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 639 E. 30th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Gladys M. Curran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe.	White	Married

6 (b) Name of husband or wife Jack M. Curran
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. , 1903

8. AGE: Years	Months	Days	If less than one day
45 44	10	?	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Hwfe.
11. Industry or business Own Home

FATHER
12. Name GeOrge Grimmel
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Emma Bachman
15. Birthplace Baltimore, Md.

16 (a) Informant Jack Curran
(b) Address 936. E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31st (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location North Ave.

18 (a) Funeral director Geo. M. Fink & Son
(b) Address 811 N. Wolfe St.

19 (a) DEC 29 1948 (Date rec'd by registrar) (b) Huntington Hollins, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1948, at 3:25AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27/ 1948 to 12/28/ 1948, and that I last saw her alive on 12/28/ 1948.

Immediate cause of death Pulmonary Embolus — Duration

Due to

Due to

Other Conditions Polycystic Kidneys & Pyonephrosis - Lobar Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony F. DiPaula M. D.
Address St. Joseph's Hosp. Date signed 12/28/48

VS 150

111a

6699:5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

6699:5 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Esplanade Apts
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 al
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade apt 7C (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hattie M. Wiesenfeld

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7/4

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Henry Mann
13. Birthplace Germany

MOTHER
14. Maiden Name Hannah
15. Birthplace Germany

16 (a) Informant Henry Wiesenfeld
(b) Address Esplanade apts 7C

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Belair Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 210 Eutaw Place

19 (a) DEC 29 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29-1948 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1929 to 12/29/1948 and that I last saw h alive on 12/29/1948.

Immediate cause of death: Cerebral Thrombosis — Duration: 7 days
Due to: Arterio sclerosis + Hypertension — Duration: Many years
Due to: Myocarditis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore H. Morrison M. D.
Address 11 E. Chase St Date signed 12/29/48

X

6699:56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

6699:56 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1643 No Appleton St
(c) Hospital or institution:
15.0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 No Appleton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Benjamin Rosenbloom

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Sadie Rosenbloom
(b) Address 1643 No Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

19 (a) DEC 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28-1948 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946 to Dec 28 1948 and that I last saw it alive on 12/27 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 hour
Due to Coronary Heart Disease	Two years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M. D.
Address 618 W 36th St Date signed 12-29-48

VS 150

6699:57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

6699:57 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital 13-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 Lakeview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martin M. Muller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Not known
13. Birthplace Germany

MOTHER
14. Maiden Name Not known
15. Birthplace Germany

16 (a) Informant Bertha Muller
(b) Address 2406 Lakeview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Hamilton Ave

18 (a) Funeral director Jack Lewis Jne
(b) Address 2406 Eutaw Place

19 DEC 29 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Dec. 1948, at 7:30? M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Fanner Jr. M.D. Medical Examiner.
Date signed 28 Dec. 48

6699:48 6699:48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-04
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Gwynns Falls Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Harriger (Nathan Horringer)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1868

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Roumania
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Medig
13. Birthplace Roumania

MOTHER
14. Maiden Name Rose
15. Birthplace Roumania

16 (a) Informant Mr. Moe Levy -
(b) Address 1700 Gwynns Falls Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. + Conklin Sts.

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Pl

19 (a) DEC 29 1948 (Date rec'd by registrar) (b) Huntington Williams Mgr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28/48 19 . at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27/1948 to 12/28/48, and that I last saw him alive on 12/28 1948.

Immediate cause of death	Duration
Pulmonary Edema	
Mesenteric Thrombosis ???	
Due to Hypertensive & Arteriosclerotic Heart Dis.	
Due to	
Other Conditions	

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Levin M. D.
Address Sinai Hosp. MD Date signed 12/28/48

VS 150

6699:59

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46B

Registered No. 6699:59

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Sedgewick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Emma
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr) 10-25-83

8. AGE: Years	Months	Days	If less than one day
65	✓	✓	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name William Sedgewick
13. Birthplace

MOTHER
14. Maiden Name Annie
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31/48 (month) (day) (year)
(c) Cemetery or crematory Sharp St Cem.
Location Chase Md

18 (a) Funeral director Mrs Robt A Eckert & Dgt
(b) Address 1129 N. Carrollton St

DEC 29 1948 (Date rec'd by Registrar) (By) Registrar

VS 150

MEDICAL CERTIFICATION 35

20. DATE OF DEATH Dec 27 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8- 1948 to 12-27 1948, and that I last saw him alive on 12-27 1948.

Immediate cause of death Cachexia — Duration

Due to Gastric carcinoma

Due to

Other Conditions chronic lymphoid leukemia (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard T. Kelly Jr.
Address JOHNS HOPKINS HOSPITAL Date signed 12/29/48

G69960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

109

Registered No. G69960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 W. Lexington Street
(c) Hospital or institution:
9-0
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 W. Lexington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Pindora Talley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Divorced

6 (b) Name of husband or wife David Talley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25, 1901

8. AGE: Years	Months	Days	If less than one day
47	0	1	hr. min.

9. Birthplace Middlesex County, VA. (Town, county, and state)
10. Usual Occupation Presser
11. Industry or business

FATHER
12. Name Perry Dixon
13. Birthplace Middlesex, VA.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant William Talley
(b) Address 1513 W. Lexington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by Registrar) (b) for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948, at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 23, 1948, to Dec. 26, 1948, and that I last saw her alive on Dec. 25, 1948.

Immediate cause of death	Duration
Pulmonary Congestion	Day
Due to Broncho pneumonia	Week
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hurst M. D.
Address 1631 W. Franklin St. Date signed 12-28-48

VS 180

669961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

669961 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address P.O.A
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 N. Carlton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sally Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife Edward Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1888

8. AGE: Years	Months	Days	If less than one day
(Dgm) 60	11	24	hr. min.

9. Birthplace Essex County, Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Matthew Jackson
13. Birthplace Essex Co., Va.

MOTHER
14. Maiden Name Harriett Campbell
15. Birthplace Essex County, Va.

16 (a) Informant Patsy Patterson
(b) Address 108 N. Carlton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Wm. Walter P. Williams
(b) Address 322 W. Lanvale St.

19 (a) (Date rec'd by registrar) (b) Wm. Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1948 at 10:40 A.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Jubinsky M.D.
Medical Examiner.
Date signed 12/25/48

0106

G69962 ✓ G69962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 935 Bennett Pl.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 61

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL or give town)
(d) Street No. 935 Bennett Pl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Foley Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Mary E. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 19, 1889

8. AGE: Years 59 | Months 4 | Days 8 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Phillip Brown
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ellen Hall
15. Birthplace Balto. Md.

16 (a) Informant Agnes Conway
(b) Address 936 Bennett Pl

17 (a) Burial (b) Date thereof 12-30-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1948, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1948 to Dec 27 1948, and that I last saw h[illegible] alive on Dec 26 1948.

Immediate cause of death	Duration
Intestinal Carcinomatosis	1
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. B. Stewart M. D.
Address 1822 W Mulberry St Date signed Dec 29

VS 150

Registrar Williams, M.D.

G69963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G69963 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 630 N. Bruce St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 03

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 630 N. Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Penson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Edward Penson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 4, 1897
8. AGE — Years: 51 Months: 8 Days: 25 If less than one day: hr. min.
9. Birthplace: Carroll Co. Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Maurice Sooner
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: John Benson
(b) Address: 1714 W. Lanvale St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-48 (month) (day) (year)
(c) Cemetery or crematory: W. Ft. Cabvary Cem.
Location
18 (a) Funeral director: Mrs Katie R Williams
(b) Address: 32 [illegible] Woodberry St
19 (a) 12/29/48 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1948 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1948 to 12-26 1948 and that I last saw h alive on 12-22 1948.

Immediate cause of death: Cm. Valvular Heart Disease — Duration: 9
Due to: Bronchitis
Due to:
Other Conditions: Myocardial Infarct
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Charles J. Wallace M. D.
Address 861 Hamburg Date signed 12-27

VS 150

669964 BALTIMORE CITY HEALTH DEPARTMENT 669964
CERTIFICATE OF DEATH 94a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 49 N. Carlton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 d
(e) Length of stay in Baltimore (yrs., mos., or days) 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 49 N. Carlton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Sparrow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife John Sparrow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1902

8. AGE: Years	Months	Days	If less than one day
46	10	—	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name	John Stokely
13. Birthplace	Md.
MOTHER 14. Maiden Name	Dora Constine
15. Birthplace	Md.

16 (a) Informant John Sparrow
(b) Address 49 N. Carlton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St
12/28/48 (b) Date rec'd by registrar Lexington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1948, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1948 to 12/24 1948, and that I last saw h[illegible] alive on 12/24 1948.

Immediate cause of death Coronary Heart Disease (Thrombosis) — Duration 3 mos.
Due to
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Preston Grant M. D.
Address 661 N. Carrollton Date signed 12/28/48

VS 150

G69965 ✓ G69965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3103 FAIT AVE.
(c) Hospital or institution: no.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 E. BIDDLE ST.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CARL O. W. ~~SHULDT~~ SCHULDT

3 (b) If veteran, name war none

3 (c) Social Security Account No. 216-09-7610A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife ANNIE W.
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) JUNE 8, 1878

8. AGE: Years	Months	Days	If less than one day
70	6	20	5 hr. 30 min.

9. Birthplace GERMANY - HAMBURG
(Town, county, and state)
10. Usual Occupation CARPENTER
11. Industry or business CONTRACTOR

FATHER
12. Name HENRY SHULDT
13. Birthplace HAMBURG GERMANY

MOTHER
14. Maiden Name IDA KROETER.
15. Birthplace HAMBURG GERMANY

16 (a) Informant CHARLES SHULDT - SON
(b) Address 3103 FAIT AVE

17 (a) BURIAL (b) Date thereof DEC 30 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Greenmount Ave. Woodlawn

18 (a) Funeral director Charles H. Fackenthal
(b) Address 703 McHenry St.

19 (a) (Date received by registrar) (b) ~~Huntington Williams M.D.~~ Registrar

DEC 29 1948
VS 150

Carl Trageser

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25th 1948 at 5:22 M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1948 to December 27 1948 and that I last saw h alive on December 27 1948.

Immediate cause of death Metastasis
1 Tuberculosis
Due to Tuberculosis of lungs
Due to
Other Conditions Bronchiectasis
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary Schuldt
Address 1023 E. N. Ave. Date signed 12/29/48 M. D.

X

G69966 XV 118 G69966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Court Ave.
(If rural give location)
(e) Citizen of foreign country? Nat (Yes or No)
If yes, name country

3 (a) FULL NAME Mr William H France

3 (b) If veteran, name war

3 (c) Social Security Account No 213-14-3440

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Isabell M. France
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/18/1872

8. AGE: Years	Months	Days	If less than one day
76	1	10	hr. min.

9. Birthplace Balto Co (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry France
13. Birthplace Md

MOTHER
14. Maiden Name Eliz Whitten
15. Birthplace Md

16 (a) Informant Mrs Wm H. France
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Ellicott City Md

18 (a) Funeral director F C Higinbotham
(b) Address Ellicott City Md

DEC 29 1948 (Date rec'd by registrar) (b) Registrar

Thanksgiving Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1948, at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1948 to Dec 28 1948, and that I last saw him alive on Dec 28 1948.

Immediate cause of death	Duration
Gastric Hemorrhage	
Due to cause unknown.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Baum M.D. M. D.
Address Balto. Hosp. Date signed 12/29/48

VS 150

X

G69967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G69967 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Box 68 Wilson Pt Rd

(c) Hospital or institution: West Balto Gen Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Middle River, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. Cypress Drive
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hobert Rutledge

3 (b) If veteran, name war

3 (c) Social Security Account No. 410-03-2566

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife Edna A. Rutledge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1st, 1897

8. AGE: Years	Months	Days	If less than one day
51	9	27	hr. min.

9. Birthplace Tenna.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Glen L. Martin Co.

FATHER

12. Name Lorenzo Rutledge

13. Birthplace Unknown

MOTHER

14. Maiden Name Laura Phillips

15 Birthplace Unknown

16 (a) Informant Mrs. Hobert E. Rutledge

(b) Address Cypress Drive, Middle River

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/30/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home

(b) Address 7401 Belair Rd.

19 (a) Date rec'd by reg. DEC 29 1948 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28th, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27/48 to 12/28/48. and that I last saw h alive on 12/28/48.

Immediate cause of death Cardiac failure

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H E Rutledge M. D.

Address West Balto Gen Hosp Date signed 12/29/48

669968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 669968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp. 47-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4519 Hamperett Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret A. Evans

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Franklin J. Evans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1917

8. AGE: Years	Months	Days	If less than one day
31	0	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Wm. P. Berry
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ada Heller
15. Birthplace Baltimore

16 (a) Informant Mr. Franklin J. Evans
(b) Address 4519 Hamperett Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto.

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 (a) 12-29-1948 (b) Thurlington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1948, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1948, to 12/29 1948, and that I last saw her alive on 12/28 1948.

Immediate cause of death Extravasal
Cachexia & Terminal Uremia

Due to Metastasis from
Carcinoma of breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Evans M.D.
Address Md. Gen. Hosp. Date signed 12/29/48

VS 190

B.C. #G69963 27758

De Lucchentis

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G69963

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11½Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 15-10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 15.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3966 Dolfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dominic Pecora

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-28-48

8. AGE: Years — Months — Days — If less than one day 12 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Dominic Joseph Pecora
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Catherine Rosemary Frank
15. Birthplace Baltimore Maryland

16 (a) Informant Dominic J. Pecora
(b) Address 3966 Dolfield ave.

17 (a) BURIAL (b) Date thereof 12-29-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Rd

18 (a) Funeral director Charles B. Zuley
(b) Address 901 S. Bonkling St.

19 (a) DEC 29 1948 (b)
(Date received by Registrar) Registrar

VS 150

Washington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/48 19 48 at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 19 48 to 12-28 19 48
and that I last saw h[illegible] alive on 12-5 19 48

Immediate cause of death	Duration
Atelectasis	
Due to: severe plaque	
Due to:	
Other Conditions: Tuberculous infiltration at apex 3 Lbs	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl Zinn M. D.
Address Bon Secours Hosp. Date signed 12-28

161a

G699.0 ✓ G699.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Gwynn Falls Pkwy
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-08
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Gwynn Falls Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME S. Catherine Heim

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Emil

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2 1878

8. AGE: Years	Months	Days	If less than one day
70	11	7	hr. min.

9. Birthplace Havre De Grace, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name William Shirley

13. Birthplace Pa.

14. Maiden Name Mary Hackett

15. Birthplace Maryland

16 (a) Informant Mr. Frank Heim

(b) Address 5616 Woodcrest Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore, Md.

18 (a) Funeral director Lemmon Bayer

(b) Address 5005 York Rd. Govanstown

19 (a) Date received by registrar DEC 29 1948 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1948, at 12 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Dec 28 1948, and that I last saw h e r alive on Dec 27 1948.

Immediate cause of death

1) Hypertensive - Cardio - Vascular Renal disease — Duration 7 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M. D.

Address 377 Frederick Ave Date signed 12/29/48

G69971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G69971 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 97 days

(e) Length of stay in Baltimore (yrs., mos., or days): 9-08

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 521 E. 20th St. (If rural give location)

(e) Citizen of foreign country? NO. (Yes or No) If yes, name country:

3 (a) FULL NAME: CHARLES FRANKLIN BOEHM

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maude Boehm

6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Oct. 31, 1894

8. AGE: Years: 54 | Months: 1 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Steward

11. Industry or business: Seafarer

FATHER

12. Name: Charles Boehm

13. Birthplace: Md.

MOTHER

14. Maiden Name: Emma K. Proctor

15. Birthplace: Md.

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/31/48 (month) (day) (year)

(c) Cemetery or crematory: Balto. National

Location: Baltimore, Md.

18 (a) Funeral director: C. Vernon Lemmon

(b) Address: 4611 Park Heights Ave.

19 (a) DEC 29 1948 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28 1948, at 3:24 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1948, to Dec. 28 1948, and that I last saw h im alive on Dec. 28 1948.

Immediate cause of death	Duration
Carcinoma type undetermined with metastasis to right 1st rib, 1st dorsal	
Due to vertebra and 2nd dorsal vertebra.	Unknown
Due to Paraplegia due to destruction of 1st and 2nd dorsal	Unknown
Other Conditions- vertebra due to carcinoma	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: John L. Wilson, Sr. Surgeon M.D.

Address: Clinical Director Date signed: 12/28/48

VS 180

G69972

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G69972 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3120 Virginia Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-16
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 Virginia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen J. Lauer

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary S. Lauer
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1868

8. AGE: Years	Months	Days	If less than one day
80	10	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired Merchant
11. Industry or business Seafood

FATHER
12. Name Wm. Simon Lauer
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Wertz
15. Birthplace Germany

16 (a) Informant Miss Magdalene Lauer
(b) Address 1001 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

DEC 29 1948 (Date rec'd by registrar) Hampton Williams, Registrar

V S 150

MEDICAL CERTIFICATION

40P.

20. DATE OF DEATH Dec. 28 1948, at 11: M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1948 to 12/28 1948, and that I last saw him alive on 12/28 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Arteriosclerosis, generalized	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maryland Edward Day M. D.
Address 4 E. 33rd St. Date signed Dec 29 1948

P.C. 48-17857
G69973

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G69973
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Shellbank Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME JANETTE FORTUNE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 21, 1948

8. AGE: Years	Months	Days	If less than one day
—	4	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Fortune
13. Birthplace Maryland

MOTHER
14. Maiden Name Johanna Webster
15. Birthplace Maryland

16 (a) Informant: James Fortune
(b) Address 1002 Shellbank Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-48 (month) (day) (year)
(c) Cemetery or crematory mt auburn
Location Md

18 (a) Funeral director George S. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date filed by registrar) DEC 29 1948 (Huntington Williams, M.D.) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1948 at 12.50p M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. (Medical Examiner)
Date signed December 29, 1948

G69974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

G69974 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Ban Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5 0 3
(e) Length of stay in Baltimore (~~yrs.~~ mos. or days) 38 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md (16) (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Alice Babel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Mr. John Abel

6 (c) If alive, give age ~~yrs~~ ? years

7. Birth date of deceased (mo., day, yr) Dec. 1, 1898

8. AGE: Years 50 | Months 0 | Days 26 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation H. W

11. Industry or business

FATHER
12. Name John W. Arnold
13. Birthplace Md

MOTHER
14. Maiden Name
15. Birthplace Md

16 (a) Informant John W. Abel Son
(b) Address 1409 N. Bentalou

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 30/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry H. Mitchell
(b) Address 401 E Edmondson Ave

DEC 29 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1948, at 12:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1948 to 12/27 1948, and that I last saw h~~e~~r alive on 12/27 1948.

Immediate cause of death: Cardiac failure
Pulmonary edema
Due to: Cerebral Embolism
Due to: Chronic Rheumatic C-V-D.
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William S. Womack M. D.
Address Ban Secours Hosp. Date signed 12/27/48

VS 180

X

G69975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G69975 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Eutaw Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County CARROLL
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID J. YOURISON

3 (b) If veteran, name war

3 (c) Social Security Account No. 109-07-6440

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret Woy
6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) March 6, 1908

8. AGE: Years	Months	Days	If less than one day
40	9	22	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business Samuel Rosoff Co.

FATHER
12. Name Samuel Yourison
13. Birthplace N. J.

MOTHER
14. Maiden Name Julia Gauer
15. Birthplace N. J.

16 (a) Informant ~~Husband of~~ the wife
(b) Address ~~4~~ 3632 Hamlin Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md

18 (a) Funeral director Harry N. Witzke
(b) Address 4101 Edmondson Ave

DEC 29 1948 (Date rec'd by registrar) Washington Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1948, at 8 A. M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured ribs.
Fractured vertebrae.
Fractured pelvis.
Lacerations of liver, lung and right kidney.

~~Other Conditions~~

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-28-48 at 6:00 A. M.
(b) Where did injury occur Liberty Rd.-Russoff Tunnel Randallstown, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell down shaft.

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/28/48

69976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 69976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST.
(c) Hospital or institution: MERCY HOSP D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 N. CHARLES ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard P. Tucker

3 (b) If veteran, name war: WORLD WAR I
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife AMY B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 31 1889

8. AGE: Years	Months	Days	If less than one day
59	10	27	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation SHOP ASSISTANT
11. Industry or business POLYTECHNIC INSTITUTE

FATHER
12. Name WILLIAM W. TUCKER
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARGARET (UNKNOWN)
15. Birthplace UNKNOWN

16 (a) Informant AMY B. TUCKER
(b) Address 1216 N. CHARLES ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/1/49 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location TAYLOR AVE

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

19 (a) DEC 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Dec. 1948, at 4:50 P. M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer Jr. M.D. Medical Examiner
Date signed 29 Dec. 48

VS 191

G69977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G69977 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2552 Oswego Ave
(c) Hospital or institution: West Balto Gen Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2552 Oswego Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Salvatore Guercio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Marie Guercio

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6th 1883

8. AGE: Years 65 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business Retired

FATHER
12. Name (Not Known) Guercio
13. Birthplace Italy

MOTHER
14. Maiden Name "
15 Birthplace "

16 (a) Informant Don Cucina
(b) Address 2552 Oswego Ave

17 (a) Burial (b) Date thereof 12/31/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) DEC 30 1948 (b) Huntington Williamsburg Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28th 1948 at 10 30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27/1948 to 12/28/1948 and that I last saw h[illegible] alive on 12/28/1948

Immediate cause of death	Duration
Gastric hemorrhage	
Due to (Arteriosclerosis (?)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Golombek M.D.
Address West Balto Hosp Date signed 12/30/48

VS (59)

G69978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G69978 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2700 Riggs Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Riggs Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine C. Leary

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband Louis T. Leary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23rd 1884

8. AGE: Years	Months	Days	If less than one day
64	11	5	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Frederick Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Pulse
15. Birthplace Balto. Md.

16 (a) Informant Thelma Emrich
(b) Address 18 S. Rosedale St.

17 (a) Burial (b) Date thereof 12/31/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 129 St. Paul St.

19 DEC 30 1948 (b) Lexington-Williams, M.D.
(Date of signature) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28th 1948 at 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19, 1948 to Dec 28 1948, and that I last saw her alive on Dec. 28 1948.

Immediate cause of death	Duration
Bilateral Hypostatic Pneumonia	
Due to Bronchitis (chronic)	
Due to Chr. myocarditis.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature George E. Shannon M.D.
Address 720 Medical Arts Bldg Date signed 12/30/48 M. D.

VS 150

669979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

669979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3819 DOLFIELD AVE.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM P. BYRD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Olevia M. Byrd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/15/71

8. AGE: Years	Months	Days	If less than one day
77	11	11	hr. min.

9. Birthplace Md.
(Town, county and state)
10. Usual Occupation Freight Conductor
11. Industry or business B & O R. R.

FATHER
12. Name Samuel Byrd
13. Birthplace Woodstock Va.

MOTHER
14. Maiden Name Sally Palmer
15. Birthplace Hagerstown Md.

16 (a) Informant Olevia M. Byrd
West End Drive, Orchard Beach Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3rd 1949 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 DEC 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1948, at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from November 16 1948, to December 29 1948 and that I last saw h/m alive on Dec 29 1948

Immediate cause of death Coronary Failure [redacted]

Due to [redacted] Insufficiency

Due to Carcinomatosis, primary site Bladder.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/23/48 12/10/48

Major findings of operation: Rt. + Left. Ureterosigmoid anastomosis.

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mand Robert Golden M. D.
Address Sinai Hospital Date signed Dec 29 1948.

VS 153

Mand Robert Golden X

G69960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G69960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St.
(c) Hospital or institution: Maryland Penitentiary 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 42 W. Hill St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Ferby, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: Black.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rintha Marshall Ferby.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-1885

8. AGE: Years 62 | Months 11 | Days 27 | If less than one day ___ hr. ___ min.

9. Birthplace Norfolk, Virginia
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business

FATHER
12. Name John F. Ferby,
13. Birthplace Newport News, Va.

MOTHER
14. Maiden Name Anna Ward
15. Birthplace Iowa City, Iowa.

16 (a) Informant Hospital Records
(b) Address Md Pen Hosp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto City

18 (a) Funeral director Isaiah F. Brown Son
(b) Address 108 W Montgomery St

19 (a) DEC 30 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23 1948, at 7 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21 1948 to 12-23 1948, and that I last saw h[im] alive on 12-23 1948.

Immediate cause of death: Myocardial infarct — Duration

Due to: Coronary thrombosis

Due to: Atherosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry W. D. Stolles, M.D.
Address Md Pen Hosp. Date signed 12-23-48

VS 150

669981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

Registered No. 669981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
2 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2729 Brooker Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY Daniels INMAN (Dorothy Daniel Fenwick)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Clarence C. Inman
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) 12-22-1929

8. AGE: Years	Months	Days	If less than one day
28	-	4	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Dressmaker
11. Industry or business

FATHER
12. Name William Daniels
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Daniels
15. Birthplace Pocomoke City, Md.

16 (a) Informant Sarah Daniels (mother)
(b) Address 424 N. Dallas Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley ave

19 DEC 30 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1948, at 3:10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-25-48 at 10:00 P.M.?
(b) Where did injury occur? 2729 Brooker Drive
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Strangulation

23. Signature Carl H. Gray M.D. Medical Examiner
Date signed 12-27-48

VS 151

669982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 E

669982 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Ashby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-18-1895

8. AGE: Years	Months	Days	If less than one day
53	1	8	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Unknown Ashly
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant: Carrie Dorsey
(b) Address 1315 E. Madison Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29-1948 (month, day, year)
(c) Cemetery or crematory Balto. Nat. Cem
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Berkley ave

19 (a) DEC 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1948, at 3 00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sabin M.D.
Medical Examiner.
Date signed 12/26/48

VS 131

G69983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G69983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 733 Sterling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM MOORE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Parthenia

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) August 1, 1917

8. AGE: Years	Months	Days	If less than one day
31	4	27	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business

FATHER
12. Name Wm. Moore
13. Birthplace Grenhen N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace N. C.

16 (a) Informant Parthenia Moore
(b) Address 737 Sterling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-1949 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1100 Bentley ave

19 DEC 30 1948 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1948, at 12:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 28/48 approx. 12:15A.M.
(b) Where did injury occur? Orleans & Forrest St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D. Medical Examiner
Date signed 12/28/48

G69984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

G69984 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 275 Exeter St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cleo Pias Gorham (Cleopias Gorham)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. ----

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: -----

6 (c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) December 4, 1923

8. AGE: Years 25 Months 24 Days - If less than one day hr. min. 21 mnt

9. Birthplace Tillery, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert L. Gorham
13. Birthplace Tillery, N. C.

MOTHER
14. Maiden Name Lucille Tillery
15. Birthplace Tillery, N. C.

16 (a) Informant Robert C. Gorham
(b) Address 618 N. Appleton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Baltimore Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1110 Bidwell ave

DEC 30 1948 (Date received by registrar) Wilmington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1948 at 5:15 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation

Due to Fire at 275 Exeter Street

Other Conditions 2° Burns hands, face and abdomen.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-25-48 at 5 A.M.
(b) Where did injury occur? 275 Exeter St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suffocation from fire

23. Signature Robert B. McFadden M.D.
Medical Examiner.

Date signed 12-25-48

VS 151

G69985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G69985
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 N. Mount Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS McKINLEY BROWNLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna Mae Brownley

6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.) October 21, 1902

8. AGE: Years 46 smt | Months 2 | Days 7 | If less than one day: hr. min.

9. Birthplace: Mathews Co., Va.
(Town, county, and state)

10. Usual Occupation: Fireman

11. Industry or business: Gas & Electric Co.

FATHER
12. Name: Henry Brownley
13. Birthplace: Mathews Co., Val

MOTHER
14. Maiden Name: Fannie ?
15. Birthplace: Mathews Co, Va.

16 (a) Informant: Edna Mae Brownley
(b) Address: 1334 N. Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-1949 (month) (day) (year)

(c) Cemetery or crematory
Location: Mathews Co. Va

18 (a) Funeral director: Elroy S. Wilson
(b) Address: 1000 Bloomfield Ave

19 DEC 30 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1948 at 8 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute pulmonary edema.
Myocardial hypertrophy
Due to and degeneration.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-28-48

VS 151

669986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

669986 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga E Calvert
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) never

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Mary's
(c) City or town ? Leonardtown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME CELESTE HERBERT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Lee Herbert
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 7-23-96

8. AGE: Years	Months	Days	If less than one day
52	5	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Henry Thomas
13. Birthplace Md

MOTHER
14. Maiden Name Lucy Branson
15. Birthplace Md

16 (a) Informant Husband
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Cem.
Location Morganza, St. Mary's Co., Md.

18 (a) Funeral director Pius B. Robinson
(b) Address Demeron, St. Mary's Co., Md.

19 DEC 30 1948 (Date received by Registrar) (b) Temporary or Millicent Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29- 1948 at 12 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-03- 1948 to 12-29-1948 and that I last saw her alive on 12-29-1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Surgical shock during 10 min Splenectomy	
Due to Splenic pneumothorax 18 mo	
Other Conditions Chronic mastoiditis rt	

(Include pregnancy within 3 months of death)

Date of operation Mastoidectomy 10-25-48 Splenectomy 12-29-48
Major findings of operation: Chronic mastoiditis of Haberterplized spleen
If autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allyn A. Judd M. D.
Address Mercy Hospital Date signed 12-29-48

VS 159

669987

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

669987
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 Harlem Ave.
(c) Hospital or institution:

17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE SENIOR

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1899

8. AGE: Years	Months	Days	If less than one day
49	3	22	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Isaiah Reed
13. Birthplace S. C.

MOTHER
14. Maiden Name Eliza J. Thomas
15. Birthplace S. C.

16 (a) Informant Mr. Thomell Senior
(b) Address 829 Harlem Ave.

17 (a) Burial (b) Date thereof 12-31-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Florence, S. Carolina.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578. W. Biddle St.

DEC 30 1948 Huntington Williams M.D.
(Date rec'd by Registrar) (Registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1948 at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26/48 to 12/28 1948
and that I last saw h alive on 19

Immediate cause of death — Duration
Cerebral Hemorrhage
Due to
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address 11 B Harlem Ave Date signed 12/29/48

G69988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G69988 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 773 Vine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDITH MALONE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	married

6 (b) Name of husband or wife John Malone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25 1915

8. AGE: Years	Months	Days	If less than one day
33 32	4	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Clarence Taylor
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Smegal
15. Birthplace Balto
16 (a) Informant Elizbeth Smegal
(b) Address 773 Vine St.

17 (a) (Burial, cremation, or removal) (b) Date thereof Jan. 1 1949 (month, day, year)
(c) Cemetery or crematory Mt Calvary
Location Balto.

18 (a) Funeral director Watts B. Smegg
(b) Address 132 W. Hamburg St.

19 DEC 30 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1948, at 2:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet Wound of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 28/48 or Exact approx. 1:30 A.M.
(b) Where did injury occur? 15 W. Lexington St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Wh[illegible] at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D. Medical Examiner.
Date signed 12/28/48

69989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

69989 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2505 Maryland Ave
(c) Hospital or institution: 12-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edouard L. Fonteneau

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia D. Fonteneau

6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) Sept. 23. 1862

8. AGE: Years 86 | Months 3 | Days 6 | If less than one day: hr. min.

9. Birthplace Philadelphia, Pa
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Edouard L. Fonteneau Sr
13. Birthplace France

MOTHER
14. Maiden Name Josepine Juillard
15. Birthplace France

16 (a) Informant Mrs. J. F. Stevenson
(b) Address 2505 Maryland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Greenmount & Oliver Sts.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 6009 Harford Road

DEC 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1945; at 3 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20/47 19 to 12/29/45, and that I last saw h alive on 12/28/45.

Immediate cause of death
Carcinoma of Prostate — Duration 22 Mos

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis W Clark M.D.
Address 3406 St Paul St Date signed 12/29/45

G69990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G69990 Registered No. 131a Hughes

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 Argyle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES E. WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1873

8. AGE: Years 75 72 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Crowdensville, Md. (Town, county, and state)

10. Usual Occupation Insurance

11. Industry or business

FATHER 12. Name Charles Williams
13. Birthplace Maryland

MOTHER 14. Maiden Name Emma (?)
15. Birthplace Maryland

16 (a) Informant Mrs. A. Geneva Watts
(b) Address 1429 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2, 1949 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) DEC 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1948, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to Dec 28 1948, and that I last saw h[illegible] alive on Dec 28 1948.

Immediate cause of death: Cardio Vascular Renal Disease — Duration

Due to

Due to

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S B Stephens M. D.
Address 1443 Druid Hill Ave Date signed Dec 30 - 48

VS 150

G69991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61 Volume

Registered No. G69991

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 N. Arlington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N. Arlington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ETTA MAE CREWS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colred

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bert L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1891

8. AGE: Years 57 | Months 11 | Days 0 | If less than one day: hr. min.

9. Birthplace Platte City, Mo.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Oldham
13. Birthplace Kentucky

MOTHER
14. Maiden Name Eva Bundy
15. Birthplace Platte City, Mo.

16 (a) Informant Mrs. Ruby Rawn
(b) Address 612 N. Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/48 (month) (day) (year)
(c) Cemetery or crematory Family lot
Location Junction City, Kansas

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) DEC 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1948, 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27, 1948 to Dec. 28, 1948 and that I last saw h[illegible] alive on Dec. 28, 1948.

Immediate cause of death: Arteriosclerosis generalized — Duration

Due to:

Due to:

Other Conditions: hypocardial failure - Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. C. G. Campbell

Address 722 N. Fulton Ave. Date signed 12-29-48 M. D.

VS 150

97

G69992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12/a

G69992 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 W. Lafayette Ave.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL WEAVER

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-01-1130

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1909

8. AGE: Years 39 | Months 3 | Days 19 | If less than one day: hr. min.

9. Birthplace Rocky Mount, N.C.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name William Weaver
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Mary Branch
15. Birthplace N. Carolina

16 (a) Informant Mrs. Julia P. Weaver
(b) Address 1020 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) DEC 30 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1948 at 4:45a/M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1948 to Dec 28 1948, and that I last saw him alive on Dec 27 1948.

Immediate cause of death Cardio Vascular Renal Disease — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Frey M. D.
Address 1428 Eutaw Pl. Date signed 12/30/48

VS 153

X

669993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61 Carr

669993 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 Whitelock Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Whitelock Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LESSIE CLARK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Gust

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 11, 1888

8. AGE: Years 60 | Months 6 | Days 16 | If less than one day: hr. min.

9. Birthplace: Robinson Co. N.C.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Andrew Brown
13. Birthplace: Robinson Co. N.C.

MOTHER
14. Maiden Name: Kitty Gregory
15. Birthplace: Robinson Co. N.C.

16 (a) Informant: Mr. Andrew Clark
(b) Address: 1121 Whitelock St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/48 (month) (day) (year)
(c) Cemetery or crematory: Fayetteville, N.C.
Location: Family lot

18 (a) Funeral director: Mrs. George H. Holland
(b) Address: 1631 Druid Hill Ave.

DEC 30 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1948, at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Jan 1944 to 27 Dec 1948.
and that I last saw her alive on 27 Dec 1948

Immediate cause of death: Uremia — Duration: 96 hrs

Due to: hypertensive cardio-vascular renal disease — 4 yrs

Due to:

Other Conditions: Diabetes mellitus — 4 yrs

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr, M. D.
Address 515 Mosher St Date signed 12-29-48

VS 150

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

69994

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 69994

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 W. Fayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. MATHIAS, SR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary B. Matthias
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10, 1873

8. AGE: Years	Months	Days	If less than one day
75	2	17	hr. min.

9. Birthplace Gloucester County, Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Britton Matthias
13. Birthplace Gloucester County, Va.

MOTHER
14. Maiden Name Johanna ?
15. Birthplace Gloucester Co., Virginia

16 (a) Informant Mrs. Mary B. Matthias
(b) Address 1114 W. Fayette Street

17 (a) Burial (b) Date thereof 1/1/49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. George A. Hallenbeck
(b) Address 1631 Druid Hill Ave.

19 DEC 30 1948 (b) Huntington Williams, M.D.
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1948, at 6:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
A.S.P.V.D.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rogg M.D.
Medical Examiner.
Date signed December 29, 1948

VS 151

G69995

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G69995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G69995

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1115 Arlington Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Arlington Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDNA L. REID

3 (b) If veteran, name war ———

3 (c) Social Security Account No. ———

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Albert O. Reid
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) October 16, 1881

8. AGE: Years	Months	Days	If less than one day
67	2	13	____hr. ____min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Dr. William Hargrave
13. Birthplace North Carolina

MOTHER
14. Maiden Name Maria Fernadis
15. Birthplace Baltimore, Maryland

16 (a) Informant Dr. Albert O. Reid
(b) Address 1115 Arlington Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Md.

18 (a) Funeral director William Chatman
(b) Address 1701 McCulloh St. Balto. Md.

19 (a) DEC 30 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1948, at 7:15A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease
Tumor of thyroid

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12-29-48 djm

VS 151

X

G69996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 184

G69996 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 Penrose Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WILLIAM ARNOLD

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Emma May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 29, 1896

8. AGE: Years	Months	Days	If less than one day
52	11	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Policeman
11. Industry or business Baltimore City

FATHER
12. Name John Henry Arnold
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura F. Haubert
15. Birthplace Maryland

16 (a) Informan: Emma May Arnold
(b) Address 2214 Penrose Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Avenue

19 (a) DEC 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1948, at 4:12 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of abdomen
Peritonitis.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/12/48 at 4:12 A.M.
(b) Where did injury occur? 900 block Little Pine St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? Yes
(d) Means of injury Firearms

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/30/48

VS 151

66997

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 33a

Registered No. 66997

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 165 W Hamilton St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 - 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 165 W Hamilton St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Edward Ellis ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
M	Col	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Feling Ellis

13. Birthplace Va

MOTHER 14. Maiden Name Alice Smith

15. Birthplace Va

16 (a) Informant Mary M Ellis

(b) Address 1622 N Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cemetery

Location Balto Md

18 (a) Funeral director Sarah L Brown Son

(b) Address 168 W Monty Gomery St

19 (a) DEC 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27th 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1948 to Dec 27 1948 and that I last saw h alive on Dec 27 1948

Immediate cause of death	Duration
(a) Acute Bronchopneumonia	7 days
Due to (b) Influenza	3 wks
Due to (c) Paralysis	1 year.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lincoln Shelton M. D.

Address 168 W. Monty Gomery St Date signed Dec 27 1948

VS 150

G69998 ✓ G69998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellamont St.
(c) Hospital or institution: Feinblatt Nursing Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 6
(d) Street No. 1701 Ellamont St. (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME LINA HANAUER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Ferdinand Hanauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28, 1863

8. AGE: Years 85 | Months 1 | Days 1 | If less than one day: hr. min.

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Emanuel Adler,
13. Birthplace Germany.

MOTHER
14. Maiden Name Babette ?
15. Birthplace Germany.

16 (a) Informant Mr. L. Hanauer,
(b) Address 3504 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Levine & Son
(b) 30-1948 1902 Eutaw Place.

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29th. 1948 at 3.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1948 to Dec 29 1948 and that I last saw her alive on Dec 29 1948

Immediate cause of death Pulmonary Edema

Due to (Generalized arteriosclerosis)

Due to

Other Conditions Cerebrovascular accident

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Matchar M. D.
Address 3623 Liberty Heights Ave. Date signed

VS 150

G69993

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G69993 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Streets
(c) Hospital or institution: Union Memorial Hospital 12-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Bradford Apts., 3301 St. Paul St. (If rural give location)
(e) Citizen of foreign country? not (Yes or No) If yes, name country

3 (a) FULL NAME Edmund Murray McCarthy

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Mrs. Anetta Grau McCarthy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1874

8. AGE: Years	Months	Days	If less than one day
74	0	4	hr. min.

9. Birthplace Nova Scotia (Town, county, and state)
10. Usual Occupation Sea captain, retired
11. Industry or business Merchant marine

FATHER
12. Name George H. McCarthy
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Lucy Anne Gracey
15 Birthplace Nova Scotia

16 (a) Informant U.M.H. records & wife
(b) Address 33rd & Calvert, Balt. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC 30 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1948, at 3:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24, 1948, to Dec. 29, 1948, and that I last saw him alive on Dec 29, 1948.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Hypertensive Cardio-vascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Lerose, M.D.
Address Union Memorial Hospital Date signed 12/29/48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

670000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ 670000 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: Jenkins Memorial 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3/4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Elmhurst Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alva A. Lamkin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Katherine E. Lamkin
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 12/26/1879

8. AGE: Years	Months	Days	If less than one day
69	0	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Judge ?
11. Industry or business

FATHER
12. Name James A. Lamkin, Sr.
13. Birthplace Va.

MOTHER
14. Maiden Name Ella Gallagher
15 Birthplace ?

16 (a) Informant Mrs. Katherine Lamkin
(b) Address 5 Elmhurst Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 30 1948 (b) [illegible] Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 1948, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946, to Dec 28 1948.
and that I last saw him alive on Dec 28 1948.

Immediate cause of death: Coronary occlusion — Duration: ?
Due to: Arteriosclerosis, hypertension, cardiovascular disease — Duration: ? yrs
Due to: — Duration:
Other Conditions — Duration:
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert J. Levickas
Address St. Agnes Hosp. Date signed 12/29/48 M.D.

Herbert J. Levickas

VS 150

70001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. 70001

PLEASE WRITE PLAINLY, WITH UNFADING INK. The information should be carefully supplied. Every item of information is especially important. Physicians: please write the causes of death clearly and legibly. correct age

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 700 W. 40th Street.

(c) Hospital or institution:

Home for Incurables (Baltimore City) 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mon. - 24 da.

(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore Md. (If outside city or Baltimore County, write RURAL, and give town)

formerly of Homewood Apts.

(d) Street No. 700 W. 40 Street. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Ella Stewart Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
F	W	

6 (b) Name of husband or wife Dr. T. Rowe Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 21, 1869

8. AGE: Years	Months	Days	If less than one day
79	2	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER

12. Name Samuel Black

13. Birthplace Baltimore, Md

MOTHER

14. Maiden Name Margaret Gauba.

15. Birthplace Baltimore Md.

16 (a) Informant S. E. Ross.

(b) Address 700 W. 40th St. - City - M

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) Dec 30 1948 (b) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1948, at 3 21 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5 1947 to Dec. 29 1948, and that I last saw h[illegible] alive on Dec. 28 19 48.

Immediate cause of death Hypertensive Cardio-Vascular Renal Disease (Cardiac Decompensation) — Duration 4 years

Due to

Due to

Other Conditions Hypertrophic arthritis — 10 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. Fraiton Herrington, M. D.

Address 1214 Cathedral St. Date signed 12/29/48

VS 130

670002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. 670002

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2675 Pennsylvania Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2675 Pennsylvania Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET FRANEY

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: John J. Franey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1870

8. AGE: Years 78 | Months 5 | Days 16 | If less than one day: hr. min.

9. Birthplace: Ireland
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER

12. Name: John Boylan

13. Birthplace: Ireland

MOTHER

14. Maiden Name: Margaret

15. Birthplace: Ireland

16 (a) Informant: Mrs. William Wernz

(b) Address: 2667 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)

(c) Cemetery or crematory: Cathedral Cem.

Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

Remington for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 19 48 about, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1943 to Dec 28 1948 and that I last saw h er alive on Dec 27 1948

Immediate cause of death: Coronary occlusion — Duration: 1 hr.

Due to: Arteriosclerosis & H.D. — 4 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature S. Hightstem M. D.

Address 8846 Lombard St Date signed 1-19-49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Information should be complete and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

670003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

670003 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mercy Hosp. 24

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5240 Reisterstown Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM H. MOTTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	213-10-1531

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Gladys E. Motter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 7, 1900

8. AGE: Years	Months	Days	If less than one day
48	2	22	hr. min.

9. Birthplace York, Pa. (Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business Balto. Transit Co.

FATHER 12. Name Charles H. Motter

13. Birthplace Pa.

MOTHER 14. Maiden Name Fannie Schwartz

15. Birthplace Pa.

16 (a) Informant Mrs. Gladys E. Motter

(b) Address 5240 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) DEC 30 1948 (Date rec'd by registrar) (b) [illegible] Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1948, at 12:50p M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1948 to Dec 29 1948. and that I last saw h[illegible] alive on Dec 29 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 day.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M. D.

Address 1012 N. Read St Date signed Dec 30 1948

VS 150

X

G70004

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G70004
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Henry Ditzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Married

6 (b) Name of husband or wife Etta Mae Ditzel (nee Hollar)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/16/1898

8. AGE: Years	Months	Days	If less than one day
50	8	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Western Electric

FATHER
12. Name Henry Ditzel
13. Birthplace Germany

MOTHER
14. Maiden Name Edith E. Allen
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Etta Hollar Ditzel
(b) Address 2326 E. Madison Street

17 (a) Burial (b) Date thereof 12/30/1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave., Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601 E. Monument St. Balto. Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 30 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1948 at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1948 to Dec 27 1948, and that I last saw h in alive on Dec 27, 1948.

Immediate cause of death	Duration
Acute Coronary Thrombosis	
Due to Arterio Sclerotic Cardio Vascular Disease	
Due to Arteriosclerosis, Generalized	
Other Conditions Cardiac Decompensation	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank W. Bahn Jr. M.D.
Address St. Joseph's Hospital Date signed 12-27-48

G70005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G70005 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 23-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & Cromwell Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. B RAMBLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Reita D. Jones Bramble
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1896

8. AGE: Years	Months	Days	If less than one day
(djm) 52	10	2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Own business
11. Industry or business Bramble Boat Yard

FATHER
12. Name John G. Bramble
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Reita D. Bramble
(b) Address 7525 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Avenue

18 (a) Funeral director SCHIMUNEK FUNERAL HOME, INC.
(b) Address 2601 E. Madison Street

19 DEC 30 1948 (Date rec'd by reg.) Washington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1948, at 1:50 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Rogers M.D.
Medical Examiner.
Date signed 12/28/48

VS 181

G70006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G70006 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Stump Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Mae Hall Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/20/1924

8. AGE: Years	Months	Days	If less than one day
24	5	5	hr. min.

9. Birthplace S.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mack Gaither
13. Birthplace S. C.

MOTHER
14. Maiden Name Nannie
15. Birthplace S.C.

16 (a) Informant Jennie Rosher
(b) Address 2830 Fox St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director CHAS. G. COOPER
(b) Address 512 Carrollton Ave.

DEC 30 1948 (b) Registrar
(Date rec'd by registrar)

Hunter for Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1948, at 1 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Kruger M.D.
Medical Examiner.
Date signed 12/27/48

G70007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 9007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 N Eden St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 N Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norman B. Sudler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna Sudler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 - 1892

8. AGE: Years: 56 | Months: 7 | Days: 23 | If less than one day: hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Sudler
13. Birthplace Md

MOTHER 14. Maiden Name Mary ?
15. Birthplace Md

16 (a) Informant Edna Sudler
(b) Address 1301 N Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) Date received by local registrar DEC 30 1948 (b) Huntington Williams M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1948, to Dec 28 1948, and that I last saw h[illegible] alive on Dec 27 1948.

Immediate cause of death	Duration
Carcinomatosis -	1 month
Due to Carcinoma Stomach	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall
Address 1631 E. North Ave Date signed Dec 29 48 M. D.

G70008 ✓ G70008

B.C. #6448 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 157a

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 630 E 28 Th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 630 E 28 Th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Belvin Perkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) NOV. 19-1946

8. AGE: Years 2 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Perkins
13. Birthplace P.

MOTHER 14. Maiden Name Mary Perkins
15. Birthplace Ala

16 (a) Informant Mary Perkins
(b) Address 630 E 28 Th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 30 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location D. C. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) DEC 30 1948 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1948 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1948 to Dec 28 1948, and that I last saw h alive on 27 Dec 1948.

Immediate cause of death Cardiac degeneration Primary anemia. — Duration 2 wks

Due to Congenital hydrocephalus — 2 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Bynum
Address 121 Eighth Date signed M. D. 12-29-48

G70009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G70009 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2609 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME May A. Helm

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Wm. A. Helm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7th 1864

8. AGE: Years	Months	Days	If less than one day
84	7	6/7	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Beckler
13. Birthplace "

MOTHER
14. Maiden Name Not Known
15. Birthplace "

16 (a) Informant Wm. Helm
(b) Address 1506 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director C. D. Fleming & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) Date received by registrar DEC 30 1948 (b) Clayton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1948, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29, 1948 to Dec. 29, 1948 and that I last saw him alive on Dec. 29 1948:

Immediate cause of death	Duration
Cerebral Hemorrhage.	Immediate
Due to Arterio-sclerosis.	?
Due to Hypertension.	?
Other Conditions ~	

(Include pregnancy within 3 months of death)
Date of operation ~
Major findings of operation: ~
of autopsy: ~

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ (Specify type of place) While at work? ~
(e) Means of injury

23. Signature Frank M. Ogden, M. D.
Address 2701 N. Calvert. Date signed Dec. 29, 1948

X

G70010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3146 Remington Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 57 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3146 Remington Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Carrie Matilda Dandy

3 (b) If veteran, name war	3 (c) Social Security Account No.
----	----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Isaac Henry Dandy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1874

8. AGE: Years	Months	Days	If less than one day
74	11	10	hr. min.

9. Birthplace New Freedom, Pennsylvania (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Calvin Ebaugh
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Butcher
15. Birthplace Pennsylvania

16 (a) Informant Joseph C. Dandy
(b) Address 4530 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore Co., Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) DEC 30 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1948, at 4.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to Dec 29 1948 and that I last saw h[illegible] alive on Dec 28 1948.

Immediate cause of death	Duration
Carcinomatosis.	
Due to Adenocarcinoma of Vulva.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L B Stevens M.D.
Address 3400 Erdman Ave Date signed 12/30/48

VS 150

X

G70011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G70011 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Russell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWARD BROWN

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 29, 1900

8. AGE: Years	Months	Days	If less than one day
48	0	27	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Volia Shane
(b) Address 1128 Russell Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebeny Mem.
Location Brooklyn, Maryland

18 (a) Funeral director ELROY O. WILSON
(b) Address 1000 Brantley Avenue

19 (a) DEC 30 1948 (Date rec'd by registrar) **(b)** Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 19 48 at 11:15A M

21. I certify that I took charge of the remains described above, held an Inq.& Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Chester J. Lubinski, M.D. M.D. Medical Examiner.
Date signed 12-27-48

VS 131

C70012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

C70012 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 647 Dover Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME FRANCIS R. WRIGHT

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 35 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Wright
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Pitts
15. Birthplace Aberdeen, Maryland

16 (a) Informant: Elsie Wright
(b) Address 735 Dolphin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month, day, year)
(c) Cemetery or crematory Baltimore National Cemetery
Location Frederick Ave.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Avenue, Huntington Williams, Md

19 (a) DEC 30 1948 (Rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1948, at 7:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide XXX homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Asphyxiation due to inhalation of illuminating-gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 27, 7:25 P.M.
(b) Where did injury occur? 647 Dover Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas range, all burners on, unlit.

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/28/48

G70013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70013 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1457 Monroe St., N. W. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR J. SULLIVAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1906

8. AGE: Years	Months	Days	If less than one day
42	5	-	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Chief Engineer
11. Industry or business Federal Bureau of Investigation

FATHER
12. Name Thomas A. Wall
13. Birthplace West Virginia

MOTHER
14. Maiden Name Bertha Manders
15. Birthplace Washington, D. C.

16 (a) Informant Ralph A. Wall
(b) Address 1617 F St., N.E., Washington, D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 3, 1949. (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Washington, D. C.

18 (a) Funeral director Albert J. Ashe
(b) Address 641 H St., N.E., Washington, D.C.
(c) [illegible]

DEC 30 1948 (Date rec'd by registrar) [illegible] Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1948, at 8:12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inq thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/30/48

G70014 BALTIMORE CITY HEALTH DEPARTMENT G70014

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3044 Arunah Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3044 Arunah Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Gertrude Lilly

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 14, 1863

8. AGE: Years	Months	Days	If less than one day
85	3	14	hr. min.

9. Birthplace Roslyn, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Andrew E. Lilly
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Cornelia Gawthrope
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Cora Lilly
(b) Address 3044 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Phillis Funeral
(b) Address 4510 Liberty Heights Ave.

19 (a) DEC 30 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1948, at 8.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1948 to Dec 28 1948. and that I last saw him alive on Dec 28 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 months
Due to Arterio Sclerosis	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Cramer M. D.
Address 4709 Liberty Hts Ave Date signed Dec 29

670015 BALTIMORE CITY HEALTH DEPARTMENT 180 Registered No. 670015

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Burnie (If outside city or town limits, write RURAL and give town)
(d) Street No. Duvall Highway & Greenhaven Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES HARTMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1888

8. AGE: Years 60 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles Hartman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Baltimore

16 (a) Informant Catherine Smith
(b) Address 608 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly & Aciler, Inc.
(b) Address 403 S. Wolfe St. Baltimore

DEC 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1948, at 1.40PM

21. I certify that I took charge of the remains described above, held an Inspection + Inq (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Toxemia from burns.
Coronary Artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-13-48 at M.
(b) Where did injury occur Duvall H'way & Greenhaven Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Conflagration of home.

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/30/48

VS 151

670016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

670016 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 23-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 S. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN M. MORAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation Unknown.

11. Industry or business

FATHER
12. Name Thos THOMAS J. MORAN
13. Birthplace IRELAND.

MOTHER
14. Maiden Name BARRETT
15. Birthplace IRELAND.

16 (a) Informant Leo W. Hughes
(b) Address 1436 Patapsco St (30)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location Baltimore Md.

18 (a) Funeral director Flynn & Flemming
(b) Address 1426 Light St (30)

(c) (Date rec'd by registrar) (d) Washington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1948, at 9:40A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12-29-48 djm

X

G70017
B.C. 48-17713

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

G70017
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 N. Central Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME TANZYA P. DUBLIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20, 1948

8. AGE: Years	Months	Days	If less than one day
	4	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Hall
13. Birthplace South Carolina

MOTHER
14. Maiden Name Mary Crawley
15. Birthplace Maryland

16 (a) Informant Mary Dublin
(b) Address 1320 N. Central Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location

18 (a) Funeral director Joseph G. Locks, Jr.
(b) Address 1304 N. Central Avenue

19 DEC 30 1948 (Date rec'd by registrar) Herrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1948, at 2.00PM

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation from inhalation of vomitus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed December 30, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G70018 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 674 Division Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSA AUSTON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?? 1891

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Jake Johnson
13. Birthplace S.C.

MOTHER
14. Maiden Name Unknown
15. Birthplace S.C.

16 (a) Informant James Walker
(b) Address 1428 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date 12/31/1949. (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Bark ~ Md

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) DEC 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1948, at 6:40 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubowski M.D. Medical Examiner.
Date signed 12/29/48 djm

X

G70019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1939

G70019 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 7144 W. Fayette St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 7144 W. Fayette St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Andrew Schlemmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mae Schultz

6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1865

8. AGE: Years	Months	Days	If less than one day
83	0	7	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Retired Clothing Cutter

11. Industry or business

FATHER

12. Name John Schlemmer

13. Birthplace Germany

MOTHER

14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Mrs Mae Schlemmer

(b) Address 7144 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director George A Fearhey

(b) Address Fulton and Fayette Sts Pennington Philadelphia, Md

19 (a) Filed by registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1948, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1939, to Dec 27 1948, and that I last saw h[illegible] alive on Dec 23 1948.

Immediate cause of death Acute cardiac dilatation — Duration 2 hrs.

Due to Chronic myocarditis — 6 yrs.

Due to Senility — 6 yrs.

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A Cohen

Address 4 N. Fulton Ave Date signed 12/29/48 M. D.

G700,20

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

G700,20 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6d.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Balto - (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Fulton Av (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ethel Talos

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Dr Andrew Talos
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 4-28-68

8. AGE: Years	Months	Days	If less than one day
40	8	2	hr. min.

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Thomas E Brannon
13. Birthplace Balto.

MOTHER
14. Maiden Name Ida Jeffries
15 Birthplace Balto

16 (a) Informant Dr. Andrew Talos
(b) Address 4 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-49 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
location Pikesville, Md
(a) Funeral director George A Farley
(b) Address Fulton and Lafayette Sts
Received rec'd by registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1948 at 12 33 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 1948 to 12-30 1948, and that I last saw her alive on 12-30 1948.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerosis	
Due to CVA	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew Talos M. D.
Address Bon Secours Date signed 12-30-48

G70021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G70021
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. Summit Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Anna Catherine Faulner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Widowed

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1871

8. AGE: Years	Months	Days	If less than one day
76	1	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name — Unknown
13. Birthplace —

MOTHER
14. Maiden Name — Unknown
15. Birthplace —

16 (a) Informant Mrs. Wm. Faulner
(b) Address 2118 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-43 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Salter Ave. - Ingleside

19 (a) (Date received by registrar) (b) Registrar

Dec 30 1943 Huntington Williams

(over)

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Dec 1943, at 2 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Dec 1943 to 28 Dec 1943. and that I last saw h.r alive on 28 Dec 1943.

Immediate cause of death	Duration
Ca. right kidney	
Due to Metastasis to liver and abd. organs.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. R. Liberto M. D.
Address Bon Secours Hosp Date signed 28 Dec 43

By 670022 of 35 Guyamo Falls Pharm.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 670022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 317 N. Monroe St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Frank H. Orendorff

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Theresa Orendorff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1900

8. AGE: Years	Months	Days	If less than one day
48	10	29	hr. min.

9. Birthplace London, Canada (Town, county, and state)
10. Usual Occupation Antique Dealer
11. Industry or business

FATHER
12. Name Leon Orendorff
13. Birthplace Canada

MOTHER
14. Maiden Name Sarah Birmingham
15. Birthplace Canada

16 (a) Informant Mrs. Theresa Orendorff
(b) Address 317 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore, Md.
(a) Funeral director George A. Farley
(b) Address Fulton Ave. & Fayette St.

18 (a) (Date rec'd by registrar) (b) Registrar

DEC 31 1948
DEC 30 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1948, at 3 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1948 to Dec 28 1948 and that I last saw h alive on Dec 29 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 hr
Due to Chronic Myocarditis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel R. Stratton M. D.
Address 1835 Guyamo Falls Pk Date signed 12/30/48

G70023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G70023 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 43 S. KOSSUTH ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) LIFETIME

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 43 S. KOSSUTH ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATIE WHALEN

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-3650

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	DIVORCED

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 3 1888

8. AGE: Years	Months	Days	If less than one day
60	5	26	hr. min.

9. Birthplace BALTO MD
(Town, county, and state)
10. Usual Occupation SEAMSTRESS
11. Industry or business

FATHER
12. Name FRED MILLER
13. Birthplace GERMANY

MOTHER
14. Maiden Name BERTHA HARTWIG
15. Birthplace BALTO

16 (a) Informant MRS. M. KEMPSTER.
(b) Address 43 S. KOSSUTH ST

17 (a) BURIAL (b) Date thereof 1-1-49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location FRED AVE

18 (a) Funeral director GEO LEIMBACH
(b) Address 526 N. LYNDHURST ST
undertaker for Williamsville, Mo.

19 (a) DEC 31 1948 (b)
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/1948 at 11:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946 to Dec 1948.
and that I last saw her alive on 12/29 1948.

Immediate cause of death Coronary Thrombosis — Duration 2 hrs

Due to

Due to

Other Conditions Arteriosclerotic CVD — 3 yrs
Diabetes
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. P. Columbus M. D.

Address 1945 N. Balto Date signed

X 12/29/48

G70024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1949

G70024 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Raspeburg (If outside city or town limits, write RURAL and give town)
(d) Street No. Philadelphia Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDGAR A. GROSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1887

8. AGE: Years	Months	Days	If less than one day
61	5	26	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Truck and Poultry

FATHER
12. Name Jacob J. Gross
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Ella M. Todd
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Gorrell.
(b) Address Phila. Rd. nr. Ridge Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/31/49 (month) (day) (year)
(c) Cemetery or crematory Orems Methodist
Location Middle River, Md.

18 (a) Funeral director Ranahan Funeral Home
(b) Address 7401 Belair Road

DEC 27 1949 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28th 1949, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1949. to Dec 28 1949. and that I last saw him alive on Dec 28 1949.

Immediate cause of death Coronary occlusion — Duration Sudden
Due to Arteria-Sclerotic Cardio-Vascular disease — Duration 1 yr
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Huntington Williams M. D.
Address Balto 6 Date signed 12-29-49

VS 150

G70025 | BALTIMORE CITY HEALTH DEPARTMENT | G70025 Registered No.

CERTIFICATE OF DEATH

170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 Violet Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris Levy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Late Rachael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Herbert Levy
(b) Address 2927 Violet Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herrin Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinsom & Bros
(b) Address 1124-1126 W. North Ave

19 (a) DEC 31 1948 (Date received by Registrar) (b) Huntingtown Williamsport, Md. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1948 19 , at 8:25 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured skull.
Hemorrhage into brain.
Terminal bronchopneumonia

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-10-48 at Approx. 5:30p. M. 15/12
(b) Where did injury occur? Park Heights Ave. at Hillsdale Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Ped. struck by auto.

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 12/30/48

670026 ✓ X 56D 670026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Also correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Linden & Madison Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 32 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: English consul (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2749 Arbutus Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3 (a) FULL NAME: Frank Page Hughes

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: 215-10-8172

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Ruth H. Hughes
6 (c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): April 2, 1893

8. AGE: Years	Months	Days	If less than one day
55	8	28	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Koppers Company Inc.
11. Industry or business:

FATHER
12. Name: George W. Hughes
13. Birthplace: New Jersey

MOTHER
14. Maiden Name: Rebbecca MacPherson
15 Birthplace: Maryland

16 (a) Informant: Mrs. Ruth H. Hughes
(b) Address: 2749 Arbutus Ave. (27)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/3/49 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore

18 (a) Funeral director: John T. Stansbury
(b) Address: 2700 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 31 1948
VS-150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/30 1948, at 4:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28 1948, to 12/30 1948, and that I last saw him alive on 12/30 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	10 hours
Due to: Tumor of right temporal lobe	2 months
Due to:	over
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: 12/30/48 Same as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Alfred H. Damm M.D.
Address: Maryland Genral Hosp. Date signed: 12/30/48

X

G70027 ✓ X G70027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23d.

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Delaware (b) County .....

(c) City or town Dover

(If outside city or town limits, write RURAL and give town)

(d) Street No. ..... (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Watson, Howard.

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife none

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) .....

8. AGE: Years	Months	Days	If less than one day
37	April 14	13, 1911	hr. ..... min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business .....

FATHER

12. Name Major Watson

13. Birthplace Delaware

MOTHER

14. Maiden Name Priscilla Kennard

15. Birthplace Delaware

16 (a) Informant Mrs Katie Carter

(b) Address 1508 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-49 (month) (day) (year)

(c) Cemetery or crematory .....

Location Dover, Delaware

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) ..... (b) Huntington Williams, M.D. (Date received) (Registrar) Registrar

DEC 31 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1948, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1948, to 12-30 1948, and that I last saw him alive on 12/30 1948.

Immediate cause of death Cardio-Respir. failure

Due to Syphilitic Aortitis

Due to Rupture of aneurysm.

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Dr. L. J. Finkell

Address From this Sq. Hos. Date signed 12/30 M. D.

Dr. Henry Parran 3-4 PM
1201 Calvert St

G70028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G70028

WITH UNFADING INK. Every item of information should be carefully supplied. The important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2876 Kentucky Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2876 Kentucky Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary V. Santora

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
Female	White	Widowed	Joseph A. Santora	years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1868

8. AGE: Years	Months	Days	If less than one day: hr.	min.
80	3	21		

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Joseph Steblitz
13. Birthplace Austria

MOTHER
14. Maiden Name Anna Herman
15. Birthplace Austria

16 (a) Informant Mary B. Santora
(b) Address 2876 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-49 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Galt, Md

18 (a) Funeral director Frank Brach & Son
(b) Address 900 W. Lafayette Ave, Baltimore, Md

56 21 1948
(Date rec'd by registrar) (b) Registrar

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1948, at 4:35A M

21. I certify that death occurred on the date above stated; that I attended deceased from September 1948 to December 1948, and that I last saw her alive on Dec 29 1948.

Immediate cause of death Septicaemia and heart failure — Duration 3 weeks

Due to decubitus ulcers following pneumonia — Duration 2 months

Due to arteriosclerotic heart failure — Duration years

Other Conditions auricular fibrillation — Duration 3 months

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry M. Parran, Jr. M. D.
Address 1201 N. Calvert St Date signed Dec 20, 1948

X

BC. H-43062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6700 29

104 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5029 Frederick a
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5029 Frederick a
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lena Harpert (HASPERT)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Wht

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 8, 1946

8. AGE: Years 2 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Adam Harpert
13. Birthplace Balto

MOTHER
14. Maiden Name Marian Pickman
15. Birthplace Balto

16 (a) Informant Adam Harpert
(b) Address 5029 Frederick a

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-1-49 (month) (day) (year)
(c) Cemetery or crematory Holy Cross 1-4-49
Location Baltimore Co. Md.

18 (a) Funeral director Frank Cracchiolo
(b) Address 700 N Eutaw St

19 (a) [illegible] (b) Date received by registrar Lington Williams, M.D. Registrar

DEC 31 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1948. at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8- 1948. to 12-30 1948.
and that I last saw him alive on 12-21 1948.

Immediate cause of death Nephrosis — Duration 9 mo.

Due to Acute pneumonia infection — 1 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John S Fenby M. D.
Address 352 E Preston St Date signed 12-30-48

G70030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

G70030
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution:
Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Youngken

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Frederick Youngken
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1866

8. AGE: Years	Months	Days	If less than one day
82	6	14	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Sanders
13. Birthplace

MOTHER
14. Maiden Name Anna Templen
15. Birthplace

16 (a) Informant Lillie Sykes, Son-in-Law
(b) Address 1200 Valley St

17 (a) Burial (b) Date thereof Jan 3, 1949
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

DEC 31 1948 (b)
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1948, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1948 to Dec 30 1948, and that I last saw h alive on Dec 28 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Mitral Stenosis	5 yrs
Due to	
Other Conditions Arteio Sclerosis	15 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. North Ave Date signed Dec 30 48

VS 150

X

G70031 ✓ G70031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 VALLEY STREET.
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 VALLEY STREET. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MISS CATHERINE P. MULLIGAN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 71 | Months | Days | If less than one day: hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Matthew Mulligan
13. Birthplace Baltimore

MOTHER
14. Maiden Name Annie
15. Birthplace Baltimore

16 (a) Informant Miss Rita Wiedefeld
(b) Address 1027 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3 1949 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 (a) 1948 (b) Registrar
(Date rec'd by registrar)

VS 153

MEDICAL CERTIFICATION A

20. DATE OF DEATH DECEMBER 30 1948 at 3.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from JANY 6 1948 to DEC 30 1948 and that I last saw her alive on DEC 30 1948.

Immediate cause of death: CHRONIC MYOCARDITIS JANUARY — Duration: 6 1948

Due to: ARTERIOR SCLEROSIS — 1940

Due to: BRONCHIAL ASTHMA. — 1940

Other Conditions: NONE

(Include pregnancy within 3 months of death)

Date of operation: NONE

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Williamson
Address 3013 ST PAUL ST Date signed DECEMBER 30 1948

G70032 ✓ X G700.32

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 62 Colonial Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY CLAYTON DANNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-5951

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Katherine Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22, 1899

8. AGE: Years	Months	Days	If less than one day
49	4	8	hr. min.

9. Birthplace Carroll County (Town, county, and state)
10. Usual Occupation Gasoline Salesman
11. Industry or business

FATHER
12. Name Henry C. Danner
13. Birthplace Carroll County

MOTHER
14. Maiden Name Clara Smith
15. Birthplace Carroll County

16 (a) Informant Emerson H. Palmer
(b) Address 100 E. Main St., Westminster

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2, 1949 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel
Location Carroll County, Md.

18 (a) Funeral director H. RANKARD, & SON
(b) Address Westminster, Maryland

DEC 31 1948 (b) (Date received by Registrar) Catherine Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1948, at 12:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull
Intracranial hemorrhage
Contusions and hemorrhage of brain
Due to Fracture of right tibia and fibula
Terminal bronchopneumonia

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 56-41
(a) Date of injury 12-26-48 at ? M.
(b) Where did injury occur? Main St., Westminster, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian struck by auto

23. Signature per George G. Merrill, M.D. M.D. (Medical Examiner)
Date signed 12-30-48

X

MAKE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6700.53 BALTIMORE CITY HEALTH DEPARTMENT 6700.53

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AARON REGISTRY SYSTEM, BALTIMORE

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28 S Ellwood Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 S Ellwood Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John G Karl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband ~~or wife~~ Myrtle Karl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6 1885

8. AGE: Years	Months	Days	If less than one day
63	9	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Pattern Park Station
11. Industry or business Post Office

FATHER
12. Name
13. Birthplace Germany

MOTHER
14. Maiden Name Catharine Starling
15. Birthplace Baltimore

16 (a) Informant Myrtle Karl
(b) Address 28 S Ellwood Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1st 1949 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Av

18 (a) Funeral director John C Mason
(b) Address 3601 Baltimore Bv

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1948, at 7:0 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1948, to Dec 29 1948, and that I last saw him alive on Dec 28 1948.

Immediate cause of death: Acute Indigestion — Duration 6 hrs.
Due to Coronary Occlusion — 2 weeks
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Conrad Gordon, M. D.
Address 2201 W. North Av Date signed 12-29-48

G70034 B.C.H. 4-28201

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70034 Registered No. 1579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 E Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 6 - Rt 16 Mace Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Russell Norman Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24-45

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace Balto Co. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Russel N. Adams
13. Birthplace Ohio

MOTHER
14. Maiden Name Kathleen MacLaughlin
15. Birthplace Balto Co Md

16 (a) Informant R N Adams
(b) Address Essex Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 31 45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto Co

18 (a) Funeral director J Bruzinski
(b) Address 1417 Eastern Ave.

DEC 31 1948 (Date rec'd by registrar) (b) Registrar for Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Dec 1948 to 29 Dec 1948, and that I last saw h[illegible] alive on 29 Dec 1948.

Immediate cause of death	Duration
pneumonia	
peritonitis	
Due to congenital atresia of small intestine, multiple	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 27 Dec 1948

Major findings of operation: Congenital atresia of small intestine

of autopsy: pneumonia & peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William V. Gross Jr., M.D.
Address Sinai Hospital, Baltimore Date signed 30 Dec (M.D.)

G70035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G.0035 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N. Luzerne Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Douglas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-11-83

8. AGE: Years	Months	Days	If less than one day
65	11 10	19	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Supt.

11. Industry or business Pathology Dept

MOTHER / FATHER
12. Name Robert Douglas
13. Birthplace Va.
14. Maiden Name Beatrice Tucker
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 31/48 (month) (day) (year)
(c) Cemetery or crematory White Marsh Mem Park
Location Brookvale Va

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Eutaw St

DEC 31 1948
(Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1948, at 12 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1948, to 12/30 1948, and that I last saw him alive on 12/30 1948

Immediate cause of death: Hepatic coma — Duration

Due to: Laennec's cirrhosis

Due to: dietary inadequacy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William O. Wisterd, M.D.
Address JOHNS HOPKINS HOSPITAL Date signed 12-30-48

67036 ✓ 67036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun
(c) Hospital or institution: Franklin Sq. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 7 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Southern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rollman, AMELIA (MOLLYE) H. ROLLMAN

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife: George Rollman
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 12/18/1868

8. AGE: Years	Months	Days	If less than one day
80	1	11	____ hr. ____ min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Hupfeld ?
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant Mrs. Helen Newnam
(b) Address 2708 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.31.48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) ____ (Date rec'd by Registrar) (b) Washington Williams, M.D. Registrar

DEC 31 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1948, at 4 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-22 1948 to 12-29 1948 and that I last saw h alive on 12-29 1948.

Immediate cause of death: Cerebral hemorrhage — Duration: ?
Due to: Hypertensive C.V. Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq Hosp Date signed 12-29-48

X

6700.37 ✓ 6700.37

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 S. Bond Street
(c) Hospital or institution:

3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Russia

3 (a) FULL NAME KASIAN TARLANSKI

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 218-10-1975

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown 1883

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Moreland Park Cemetery

FATHER
12. Name Kasian Tarlanski
13. Birthplace Volin, Russia

MOTHER
14. Maiden Name ?
15. Birthplace Russia

16 (a) Informant: Rev. John Govrusik
(b) Address 2028 E. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 1, 1949 (month) (day) (year)
(c) Cemetery or crematory St. Andrews Cemetery
Location German Hill Road

18 (a) Funeral director Dippel Brothers
(b) Address 1800 E. Lombard Street

19 DEC 31 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 19 11:15 P. M

21. I certify that I took charge of the remains described above, held an Inspection + Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George C. Merrill M.D.
Medical Examiner.
Date signed 12/30/48

VS 151

G70038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

G70038
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3821 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Kairys

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Moses Katzuda
13. Birthplace Russia

MOTHER
14. Maiden Name Rosa
15. Birthplace Russia

16 (a) Informant Harry Kairys
(b) Address 3504 Rosedale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Levy Inc
(b) Address 2100 Eutaw Place

19 (a) 1948 (Date filed by registrar) Thurston Williams, M.D. Registrar
C 81

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30- 1948, at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28- 1948, to 12-30- 1948, and that I last saw h alive on 12-30- 1948.

	Duration
Immediate cause of death Acute coronary occlusion	
Due to Arteriosclerotic heart disease and	
Due to Hypertensive cardiovascular disease	
Other Conditions Acute gangrenous appendicitis - appendicial abscess	

(Include pregnancy within 3 months of death)
Date of operation 12-29-48
Major findings of operation: Acute gangrenous appendicitis - appendicial abscess
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature
Address Sinai Hospital Date signed 12-30-48 M. D.

VS 150

(700.39)

MEDICAL EXAMINERS CASE
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

(700.49) Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 Elmer Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 18
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Elmer Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellis I Skow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1875

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Romania (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Romania

MOTHER
14. Maiden Name not known
15. Birthplace Romania

16 (a) Informant Ralph I Skow
(b) Address 1105 Elmer Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (12-01-48) (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) DEC 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30-1948, at 2:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 1944, to 12-30 1948, and that I last saw h I'm alive on 12-30 1948.

Immediate cause of death: Coronary occlusion — Duration: 3 hours
Due to: Arteriosclerotic Heart disease
Due to:
Other Conditions: Fracture of left femur (neck) — 7 mos.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

CERTIFICATION APPROVED BY
Dwight H. Merrill M.D.
CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 4/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence May 27 1948 at P.M
(c) Where did injury occur? Balto. Md. Baltimore & Para Streets
(d) Did injury occur about home, on farm, industrial place, in public place? Boarding street car While at work? No
(Specify type of place)
(e) Means of injury Fell off step of car

23. Signature Louis I. Blum, Jr. M.D.
Address 2310 Eutaw Pl. Date signed 12/31/48

X

P.C. 48-28299
6700.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6700.0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day, 5Hrs., 10Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Halethorpe - 27, Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Arbutus Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Mary Stromberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-29-48

8. AGE: Years | Months | Days: 1 | If less than one day: 5 hr. 10 min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Bernard Stromberg
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Beatrice Snape
15. Birthplace Scotland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director George A. Fuller
(b) Address Fulton Ave. & Fayette St.

19 (a) [illegible] (b) Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31- 1948 at 4:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1948 to 12-31 1948 and that I last saw her alive on 12-31 1948.

Immediate cause of death: Pulmonary Atelectasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Bon Secours Date signed 12-31

Huntington Williams, M.D.
Coroner Carroll Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

670041

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

45B

670041 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Calhoun Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY BIGERS (HARRY BIGGERS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1885

8. AGE: Years	Months	Days	If less than one day
63	9	28	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Abraham Biggers
13. Birthplace Maryland

MOTHER
14. Maiden Name Addie Young
15. Birthplace Maryland

16 (a) Informan: Howard Biggers
(b) Address 1710 N. Fulton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-49 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St.

19 (a) DEC 31 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1948, at 10:10AM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of tongue

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robt. Falconi M.D. Medical Examiner.
Date signed 12-29-48 djm

6700-2 ✓ 6700-2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 760 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SHARLET BOYKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife Charles Boykins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 5, 1897

8. AGE: Years	Months	Days	If less than one day
51	8	21	hr. min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Clarah Boykins
(b) Address 1005 W. Lenvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month, day, year)
(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director George Nelson
(b) Address 1303 Presstman St.

19 (a) 31 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1948 19 , at 10:10 M

21. I certify that I took charge of the remains described above, held an Inspection & Inq thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/30/48

VS 151

G70043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70043 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5911 Cedonia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise Carrie Boemmel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife Andrew Ignatius Boemmel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1900

8. AGE: Years	Months	Days	If less than one day
48	0	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Wife.
11. Industry or business Own home

FATHER
12. Name Frank Rose
13. Birthplace Md.

MOTHER
14. Maiden Name Anna
15. Birthplace Md.

16 (a) Informant Mr. Andrew Boemmel
(b) Address 5911 Cedonia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Co.

18 (a) Funeral director L. J. Luck
(b) Address 530 Harford Rd.

19 (a) (b) (State registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1948, at 2:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 25, 1948, to Dec. 29, 1948, and that I last saw her alive on Dec. 29, 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral hemorrhage	
Due to Arteriosclerotic Cardio-vascular disease	
Other Conditions Arteriosclerosis Generalized (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker Jr. M. D.
Address St. Joseph's Hosp. Date signed 12-29-48

VS 150

Dr. W. Arthur Darby 6700-4
Medical Arts Bldg.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97 6700-4
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret E. Farley

2. DATE OF DEATH: Dec. 31, 1948

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2859 W. Lafayette

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2859 W. Lafayette Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 2859 W. Lafayette Avenue 16-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widowed	Feb. 23, 1870	78	10	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Miller

14. MOTHER'S MAIDEN NAME: ? Schleiker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Mary E. Farley, ADDRESS 2859 W. Lafayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis.
DUE TO
(A) Cerebral Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 hour

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1938, 19__, *to* Dec 31, 1948, *that I last saw the deceased alive on* Dec 31, 1948, *and that death occurred at* 3:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE: W. A. Darby, M. D.

23B. ADDRESS: 810 Medical Arts Bldg

23C. DATE SIGNED: Dec 31, 1948

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 3, 1948	Parkwood Cem.	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR:

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road.

DEC 31 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G70045 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 434 Ilchester Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 434 Ilchester Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTUS F. RIVERS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Lillian R. Rivers nee Gould
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 24, 1873

8. AGE: Years 75 | Months 2 | Days 5 | If less than one day: hr. min.

9. Birthplace: Phila., Pa. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: Augustus Rivers
13. Birthplace: Canada

MOTHER
14. Maiden Name: Elizabeth
15. Birthplace: Unknown

16 (a) Informant: Mrs. Lottie M. Freeman
(b) Address: 434 Ilchester Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/1/49 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 DEC 31 1948 (Date rec'd by registrar) (b) Carrington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27, 1948, to Dec. 29, 1948, and that I last saw her alive on Dec. 27, 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage.	Immediate
Due to Arterio-sclerosis	?
Due to Hypertension	?
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation: ✓
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place) ✓
(e) Means of injury

23. Signature Frank M. Ogden. M. D.
Address 1701 N. Calvert St. Date signed Dec. 30, '48

PRESS FIRMLY WITH UNFADING INK. Entry of information should be carefully studied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70046 ✓ G70046

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address _____
(c) Hospital or institution: MARYLAND GEN. HOSP 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4013 HAYWARD AVE #15 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If so, name country _____

3 (a) FULL NAME MRS. FRANCES Priscilla MERRITT

3 (b) If veteran, name war —

3 (c) Social Security Account No. _____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife CLEVELAND V. MERRITT
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) JUNE 10, 1887

8. AGE: Years	Months	Days	If less than one day
61	6	20	_____ hr. _____ min.

9. Birthplace Belair MARYLAND (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name Isaac P. Shertzer
13. Birthplace Churchville, Md.

MOTHER
14. Maiden Name Mary Eliz. Price
15. Birthplace Phoenix, Md.

16 (a) Informant HUSBAND
(b) Address SAME AS DECEASED

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (b) [illegible] Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 DECEMBER 48 at 4:32 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 27DEC 1948 to 30DEC 1948, and that I last saw HER alive on 30DEC 1948.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	
Due to CEREBRAL HEMORRHAGE, RIGHT FRONTAL LOBE	3DAYS
Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE	15 YRS
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation _____
Major findings of operation: _____
of autopsy: -ABOVE CAUSE OF DEATH

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Donald J. England M. D.
Address MARYLAND GEN. HOSP. Date signed 30DEC48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G700-7

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G700-7
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette.
(c) Hospital or institution: Bon Secours Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 82 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 756 Carroll St, Balto 30.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT FERDINAND BUCHAL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5-13-66

8. AGE: Years	Months	Days	If less than one day
82	7	17	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation — retired
11. Industry or business —

FATHER
12. Name Robert Buchal
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Mahn
15 Birthplace Germany

16 (a) Informant Miss Carrie Buchal (Sister)
(b) Address 756 Carroll St. Balto 30.

17 (a) Burial (b) Date thereof 1/3/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) DEC 31 1948 (b) Transcription from Baltimore, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1948, at 4.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1948 to Dec. 30 1948, and that I last saw him alive on Dec. 30 1948.

Immediate cause of death	Duration
Cardiac Failure.	
Due to Coronary Thrombosis	
Due to	
Other Conditions Pneumonia C-V. disease.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Carlos J. Castellanos M. D.
Address Bon Secours Hosp. Date signed 12.30.48

VS 150

X

G70048 ✓ G70048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4303 Liberty Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4303 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM B. MAGRUDER

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 212-03-1534

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Viola A. Magruder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1891

8. AGE: Years 57 | Months 6 | Days 9 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Sec'y. & Treas.

11. Industry or business Monumental Storage

FATHER
12. Name George D. Magruder
13. Birthplace Md.

MOTHER
14. Maiden Name Charlotte Brady
15. Birthplace Md.

16 (a) Informant Mrs. Viola A. Magruder
(b) Address 4303 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 31 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1948, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1948, to Dec. 30 1948 and that I last saw him alive on Dec. 30 1948.

Immediate cause of death: (a) Coronary Thrombosis — Duration: 4 hrs.

Due to

Due to

Other Conditions. - None

(Include pregnancy within 3 months of death)

Date of operation - None

Major findings of operation:

of autopsy: - No.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.

Address 4106 Liberty Hts Date signed 12/31/48

G70049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G70049 Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Entry must be made for every item. If unknown, supply best information obtainable. Be sure to report correct age in years. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3306 Fleet St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Haas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Minnie W. Altvater
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1869

8. AGE: Years	Months	Days	If less than one day
79	2	18	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Haas
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15 Birthplace Germany

16 (a) Informant Mrs. Minnie W. Haas
(b) Address 3306 Fleet St.

17 (a) Burial (b) Date thereof 1/1/49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 Date rec'd by registrar DEC 31 1948 by Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29- 1948 at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2- 1947 to 12-29 1948 and that I last saw him alive on 12-28 1948.

Immediate cause of death	Duration
Arteriosclerotic Hypertensive C. V. Disease	12-2-47
Due to Cerebral Hemorrhage	12-26-48
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl Schumunk M. D.
Address 842 E. 4th Rd. Date signed 12-30-48

G70050 BALTIMORE CITY HEALTH DEPARTMENT ✓ X G70050

CERTIFICATE OF DEATH

170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 mins.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Winchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES W. EATON

3 (b) If veteran, name war	3 (c) Social Security Account No.
1 War	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 8, 1876

8. AGE: Years	Months	Days	If less than one day
72	1	22	hr. min.

9. Birthplace Capon Bridge, West Virginia
(Town, county, and state)

10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Halethorpe Police
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/48 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director B A Giffen (Name)
(b) Address Capon Bridge W. Va.

19 DEC 31 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1948, at 8:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed Chest
Multiple Fractures
Due to Ruptures of Liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 53-00

(a) Date of injury 12/30/48 at 8:50 P.M.
(b) Where did injury occur? Washington Blvd. at Sulphur Spring Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work? No
(d) Means of injury Struck by taxicab.

23. Signature Earl Royer M.D.
Medical Examiner.
Date signed 12/31/48

VS 181

X

AB-121625

G70051

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 47c

G70051 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1048 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Floyd

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4 1879

8. AGE: Years	Months	Days	If less than one day
69	4	23 ?	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jim Floyd
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Floyd
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mr. Kotes R. Williams
(b) Address 922 N. Longwood St.

19 (a) 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27- 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28- 1948, to 12-27- 1948 and that I last saw him alive on 12-27- 1948.

Immediate cause of death	Duration
BRONCHOPNEUMONIA	3 WEEKS
ATELECTASIS	5 MONTHS
Due to BRONCHOGENIC CARCINOMA	9 MOS ?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: NONE
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jernigan M. D.
Address BALTIMORE CITY HOSP Date signed 12-28-48

Please write plainly, with pen and ink. Do not use pencil. Be sure that every item is correct and complete. Physicians: please write the causes of death clearly and legibly. Underlining is especially important.

VS 150

X

G70052

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70052 ✓ 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 947 Bennett Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 947 Bennett Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joanna Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Edward Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1880

8. AGE: Years 68 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Charles Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Luckett

13. Birthplace Charles Co. Md.

MOTHER 14. Maiden Name Cecelia Day

15. Birthplace Charles Co. Md.

16 (a) Informant Cecelia Grant

(b) Address 947 Bennett Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location

18 (a) Funeral director Miss Katie R. Gilliland

(b) Address 3227 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) By Mrs

Contington Williams

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28- 1948. at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9, 1948. to Dec. 1948. and that I last saw her alive on Dec. 28, 1948.

Immediate cause of death Congestive heart failure — Duration

Due to Chronic myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O.R. Southall M. D.

Address 718 Dolphin St. Date signed 12-31-48

X

FOR USE WHERE PERMITTED BY LAW. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G70053 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 N. Pine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife William Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1890

8. AGE: Years	Months	Days	If less than one day
58	3	14	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Clark
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Charity Myers
15. Birthplace Baltimore, Maryland

16 (a) Informant Thelma Robinson
(b) Address 1658 Delano Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-48
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Katie R. Williams
(b) Address 322 N. Schroeder Street

DEC 31 1948 (Date rec'd by registrar) (b) Burton for Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1948, at 11:35 A.M.

21. I certify that I took charge of the remains described above, held an Inspection and Exam thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-28-48

6700-4 BALTIMORE CITY HEALTH DEPARTMENT 6700-4

CERTIFICATE OF DEATH

BIRTH NO. 13/a Registered No.

1. NAME OF DECEASED (Type or Print): Lear-Bierbower Kimsey
2. DATE OF DEATH: 12-31-48

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto-City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 100 E Lafayette Ave
c. Length of stay in Baltimore: 50 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — B. COUNTY: 100 E Lafayette Ave
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 12-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Sept 13-1877	71	3 / 18	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House - Wife		Harrisburg PA	

13. FATHER'S NAME: Robert Patton
14. MOTHER'S MAIDEN NAME: Miss Bierbower — Mar-9A-04

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	None	None		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac arrhythmia — DUE TO
(B) Cardio Renal Disease — DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 7 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 14 1941 *to* 12-31-1948, *that I last saw the deceased alive on* 12-31-1948, *and that death occurred at* 11:30 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. N. Thomas M. D.	3186 Harford Rd	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1-1-49	Camp Hill	Camp Hill PA

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
1/1/49	Thurlington Williams, M.D.	Earl B Wolverton	403 E 25th St.

VS/150

Please write clearly, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G700.5 | BALTIMORE CITY HEALTH DEPARTMENT | G700.5

CERTIFICATE OF DEATH 51B

Registered No. ____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 S. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sigmunt STEPHAN (STEFANOWICZ)

3 (b) If veteran, name war.
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2-1854

8. AGE: Years	Months	Days	If less than one day hr.	min.
94	7	29		

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Steam Ship agent
11. Industry or business

FATHER
12. Name John Stefanowicz
13. Birthplace Poland

MOTHER
14. Maiden Name Veronika P. Miczkiewicz
15. Birthplace Poland

16 (a) Informant Charlotte Kubiak
(b) Address 520 S. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto. City

18 (a) Funeral director Wm. S. Tialkowski
(b) Address 2007 Eastern ave

19 (a) 1/1/48 (Date received by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1948, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Dec 30 1948, and that I last saw him alive on 12/30 1948.

Immediate cause of death Pulmonary Oedema + Cardiac failure Uremia Anuria — Duration 4-5 days

Due to Adenomatous Carcinoma of the prostate + urinary bladder (2 distinct tumors) — Duration 3-4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation June 1947
Major findings of operation: Bladder tumor urinary + Carcinoma of the prostate
of autopsy: was an autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John S. Hamer M. D.
Address 11 E. Chase St. Date signed 12/31/48

VS 150

Balto 2 X

Please write plainly, with pen or indelible pencil. Give number of information wherever necessary suggested. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70056

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 c

G70056 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1735 Maryland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES H GREEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1884

8. AGE: Years	Months	Days	If less than one day
64	2	4	hr. min.

9. Birthplace Caroline Co. Va.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Alfred Green
13. Birthplace Caroline Co. Va.

MOTHER
14. Maiden Name Lottie Ware
15. Birthplace Caroline Co. Va.

16 (a) Informant Mrs. Laura G. Green
(b) Address 519 Jackson Ave. Jersey City N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2, 1949 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson, Maryland.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) 1/1/49 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1948 at 8:30p M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1948 to Dec 29 1948
and that I last saw him alive on Dec 29th 1948.

Immediate cause of death Endocarditis — Duration 8 hours

Due to Rheumatism

Due to diet & hard work

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D G Scott M. D.
Address 354 N. Biddle Date signed 12-31-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6700-7 ✓ 6700-7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 518 W. Preston Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 518 W. Preston Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE MANILY SR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1888

8. AGE: Years 60 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Halifax, N.C. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER

12. Name UNKNOWN

13. Birthplace

MOTHER

14. Maiden Name UNKNOWN

15. Birthplace

16 (a) Informant Mr. George B. Manily Jr.

(b) Address 882 W. 45th. St. Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 1/1949 (month) (day) (year)

(c) Cemetery or crematory Family Lot

Location Seldon, N. C.

18 (a) Funeral director Mrs. George [illegible] Garland

(b) Address 1681 Druid Hill [illegible]

19 (a) 1/1/49 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1948 at 3:45a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1948 to Dec 29 1948, and that I last saw him alive on Dec 27 1948.

	Duration
Immediate cause of death: Uremia	1 wk.
Due to: Hypertensive cardiovascular renal disease	Intermit.
Due to:	
Other Conditions: mild congestive Heart Failure (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Garland Quinn M.D.

Address 902 W. Franklin Date signed 12-29-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6700-8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

6700-8 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Worcester
(c) City or town Pocomoke City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Smack Hydrick

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	W.	Married

6 (b) Name of husband or wife Edgar L. Hydrick
6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Nov 5-1927

8. AGE: Years	Months	Days	If less than one day
21	1	24	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Frank M. Smack
13. Birthplace Md

MOTHER
14. Maiden Name Ethel Richardson
15. Birthplace Md

16 (a) Informant Edgar L Hydrick
(b) Address Pocomoke Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2-49 (month) (day) (year)
(c) Cemetery or crematory Hallie Wells Baptist Church
Location Pocomoke Md

18 (a) Funeral director Watson Funeral Home
(b) Address Pocomoke Md

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Dec 1948 at 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 22 Nov 1948 to 29 Dec 1948 and that I last saw her alive on 29 Dec 1948.

Immediate cause of death Rupture of Congenital Aneurysm Rt. Middle Cerebral artery

Due to Subdural hemorrhage

Due to

Other Conditions Intracerebral Hemorrhage Secondary to Rupture of Aneurysm

(Interval between onset and death) within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

Duration
Sudd.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George M. Smith M.D.
Address University Hosp Date signed 29 Dec 48

VS 150

X

G700 59 ✓ G700 59

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 114a

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Maryland General Hosp. 25.4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4123 5th Ave # 25 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Benjamin Ireland

3 (b) If veteran, name war /
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Nettie
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-31-1874

8. AGE: Years	Months	Days	If less than one day
74	9	0	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Employee of the
11. Industry or business General Refg. Co.

FATHER
12. Name James
13. Birthplace Md.

MOTHER
14. Maiden Name Barbara ?
15. Birthplace Md

16 (a) Informant Family
(b) Address Same.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-3-49 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director James L. McCann
(b) Address 130 S. Fort Ave

19 (a) 1/1/49 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 19 48, at 3:45 P M

21. I certify that death occurred on the date above stated that I attended deceased from 12/28 19 48 to 12/31 19 48
and that I last saw him alive on 12/30 19 48

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia, (Lobar)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: Extensive Pneumonia c Pulmonary Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify home, farm, etc.) While at work? .....
(e) Means of injury .....

23. Signature Charles J. Blank M. D.
Address Maryland General Date signed 12/31/48

485-303 ✓ x 164

G70060 BALTIMORE CITY HEALTH DEPARTMENT G70060

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) George Greenwell

2. DATE OF DEATH JAN 1 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY St. Mary's
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hollywood.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Single	8-30-81	67 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY ?

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wm Thomas Greenwell

14. MOTHER'S MAIDEN NAME Sarah Redmond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mediastinal tumor, ? carcinoma — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Arteriosclerotic heart disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-27- 1948 *to* 1-1- 1949 *that I last saw the deceased alive on* 1-1- 1949, *and that death occurred at* 12 15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William W. Dintenfass M. D.	JOHNS HOPKINS HOSPITAL	1-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 4 1949	St Johns	Hollywood St Mary's Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
1-4-49	Huntington Williams, M.D.	W. S. Mattingley Sons Leonardtown, Md.

VS 150

47F

G700o1 ✓ X G700o1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

151 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Rural (Stewartstown, Penn.)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural Delivery
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Marion Kirkwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband ~~or wife~~ Mr. Stuart R. Kirkwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-21-1877

8. AGE: Years	Months	Days	If less than one day
71	8	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr. Franklin Anderson
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Jackson
15. Birthplace Maryland

16 (a) Informant Mrs. J. L. Kirkwood
(b) Address 708 E. 21st St. Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 4 49 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Jarrettsville Maryland

18 (a) Funeral director W. Maynard Wright
(b) Address Forest Grove, Pa

19 (a) 1/7/49 (Date rec'd by registrar) (Signature) for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1949 at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 1948 to Jan. 1 1949. and that I last saw h~~er~~ alive on 1-1- 1949.

Immediate cause of death Carcinoma of Stomach — Duration

Due to [redacted]

Due to

Other Conditions Bronchopneumonia left lower lobe
(Include pregnancy within 3 months of death)

Date of operation 12-21-48

Major findings of operation: Carcinoma of Stomach -

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Hopkins, III
Address Union Memorial Hosp. Date signed 1/1/49 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

46C

A67622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

192.0 G70062 Registered No.

BIRTH NO. G70062

1. NAME OF DECEASED (Type or Print): Betty Jane Naylor

2. DATE OF DEATH: JAN 2 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sparks
D. STREET ADDRESS (If rural, give location):

5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: 12-4-42
9. AGE (In years last birthday): 6 years
If Under 1 Year: Months: Days: 29
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Naylor
14. MOTHER'S MAIDEN NAME: Myrtle Wilhelm

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) intracranial metastases of

DUE TO

(B) retinoblastoma.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: April 1946
19B. MAJOR FINDINGS OF OPERATION: retinoblastoma of rt. orbit.
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-31- 1948 *to* 1-2- 1949, *that I last saw the deceased alive on* 1-2- 1949 *and that death occurred at* 2.45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: W Lawson MD M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-4-49
24C. NAME OF CEMETERY OR CREMATORY: Falls Rd. Chapel
24D. LOCATION (City, town, or county) (State): Butler, Balto Co., Md

DATE RECEIVED BY LOCAL REGISTRAR: 1/7/49
REGISTRAR: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: Landon M. Brooks
ADDRESS:

VS 150

54a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70063 BALTIMORE CITY HEALTH DEPARTMENT G70063

CERTIFICATE OF DEATH 46E

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Isabelle V. King

2. DATE OF DEATH: December 30, 1948

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4703 Hampnett Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pineridge Conv. Home

c. Length of stay in Baltimore: Yrs. life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1706 Ellamont St. 15-6

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: March 17, 1870
9. AGE (In years last birthday): 78 — If Under 1 Year: Months 9, Days 13 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard R. Barclay
14. MOTHER'S MAIDEN NAME: Susannah S. Vaughn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Leo Hayden King ADDRESS: 3206 Prestmann St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 22, 1947, *to* Dec. 30, 1948, *that I last saw the deceased alive on* Dec 18, 1948, *and that death occurred at* 6:30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Abraham B. Hurwitz M. D.
23B. ADDRESS: 3048 W. North Avenue
23C. DATE SIGNED: 12/31/48

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1 - 3 - 48
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): Woodlawn, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: 1/2/49
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: John C. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Place

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G700c4 ✓ 550.1 G700c4

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address (100 E. 23rd St)
(c) Hospital or institution: Beck's Diagnostic Clinic, IV
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County _____
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3 (a) FULL NAME Miss Katherine Lederer

3 (b) If veteran, name war: —
3 (c) Social Security Account No.: _____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	White	Single

6 (b) Name of husband or wife: —
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) January 8, 1865

8. AGE: Years	Months	Days	If less than one day
83	11	13	_____ hr. _____ min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation housewife.
11. Industry or business

FATHER
12. Name Michael A. Lederer
13. Birthplace Germany

MOTHER
14. Maiden Name Annmaria L. Lederer
15. Birthplace Germany

16 (a) Informant George J. Parker
(b) Address 5209 York Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 3/49 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Road

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) 1/2/49 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1948 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1926 to Jan 1 1949, and that I last saw h alive on Jan 1 1949.

Immediate cause of death	Duration
Generalized arteriosclerosis	Indefinite
Myocarditis	
Due to Shock & Weakness	3 hours
Following Appendectomy &	
Due to Peritonitis - from	
which she recovered	
Other Conditions Pneumonia,	Indefinite
Acute psychosis	2 days

(Include pregnancy within 3 months of death)
Date of operation October 28 - 48
Major findings of operation: Ruptured appendix & peritonitis
of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at _____ M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Nathaniel M Beck, M. D.
Address 100 E. 23rd St Date signed Jan 1-49

VS 150

937

G70065 BALTIMORE CITY HEALTH DEPARTMENT 331.0 G70065

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edith J. ALBRECH
2. DATE OF DEATH: JAN. 1. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1649 E. 25th St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1649 E. 25 St.
c. Length of stay in Baltimore: 28 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 1649 E 25 St, B COUNTY Baltimore City Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D STREET ADDRESS (If rural, give location): 1649 E. 25 St 4-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	White	Widowed	January 17 1863	85	11	14

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Retired Dressmaker	Taylor	Shepherdtown W. Va.	U.S.A.

13. FATHER'S NAME: JOHN P. ANTLER
14 MOTHER'S MAIDEN NAME: Amelia L. WALTERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	None	Mrs J. Harry L. Rust	1649 E 25 St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Cerebral Hemorrhage
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Ch Arteriosclerosis
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/24 1948, to 12/31, 1948 *that I last saw the deceased alive on* 12/31, 1948, *and that death occurred at* 7:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. L. Hometein M. D.	704 E. Biddle St	1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 3, 1949	Elmwood Cemetery	Shepherdtown W. Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
1/3/49	Huntington Williams, M.D.	Elmer W. Conklin	924 E. Eager St.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HS 150

83a

BIRTH NO. G700656

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.0 G700676 Registered No.

1. NAME OF DECEASED (Type or Print): Michael McCabe

2. DATE OF DEATH: 1/1/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 918 E. Chase St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits write RURAL and give township) Baltimore Md; D. STREET ADDRESS (If rural, give location) 918 E. Chase St 10-1

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 918 E. Chase St

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	SINGLE	April 1 1890	58	9	0		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lamp Trimmer

10B. KIND OF BUSINESS OR INDUSTRY: Gas & Electric Co

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Simon McCabe

14. MOTHER'S MAIDEN NAME: Margt McCall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

16. SOCIAL SECURITY NO.

17. INFORMANT: John J. McCabe ADDRESS: 918 E Chase St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C.V. disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* _____ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: C. J. Sulkowski M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED: 1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-4-1949	New Cathedral	4300 Old Frederick Rd Md

DATE RECEIVED BY LOCAL REGISTRAR: 1/2/49 | REGISTRAR'S SIGNATURE: [illegible] Baltimore, Md | 25. FUNERAL DIRECTOR: Edmund W Conklin ADDRESS: 924 E. Eager St.

VS 151

93D

POLICE: WHEN A CORONER'S CASE, WRITE CORONER'S NAME AND THE CAUSES OF DEATH CLEARLY AND LEGIBLY. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

428.W.3. G70067 B.C.H-8-8374

BALTIMORE CITY HEALTH DEPARTMENT G70067 67

CERTIFICATE OF DEATH 87E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Turners Station (If outside city or town limits, write RURAL and give town)
(d) Street No 107 Everett Lane Silas House (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Bernice Elizabeth Simpson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-17-43

8. AGE: Years	Months	Days	If less than one day
5	5	13	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Moses Simpson
13. Birthplace S. C.

MOTHER
14. Maiden Name Lilly Groint
15. Birthplace S. C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2/49 (month) (day) (year)
(c) Cemetery or crematory Mt Cressy
Location A A County
18 (a) Funeral director McDuffie Funeral Home
(b) Address 1129 N. Caroline St
19 (a) 12/2/49 (Date rec'd by registrar) (b) Washington Hollins Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30- 1948, at 5 29 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1- 1948 to 12-30- 1948, and that I last saw her alive on 12-30- 1948.

Immediate cause of death
Cerebral degeneration
Due to
Due to of unknown etiol.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Simpson M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B.C. 48-12359 G700:8 G700:8 67

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Avenue
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Vincent's Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Lynch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/13/48

8. AGE: Years	Months	Days	If less than one day
	7	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Beatrice Lynch
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burrie (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Dorman Ave & True Rope

18 (a) Funeral director Fahey Bros
(b) Address 1318 Light St

19 (a) 1/2/49 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30/ 1948, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him alive on 12-30 1948.

Immediate cause of death Acute Cardio-resp. failure.
Due to Internal Hydrocephalus.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cuthbert T. Hall Jr. M. D.
Address St. Agnes Hosp. Date signed 12/31/48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67003 BALTIMORE CITY HEALTH DEPARTMENT 420.1 67003

BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): MAMIE HERMAN.

2. DATE OF DEATH: JAN 1st-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1055 S.CHARLES ST

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE City-1055 S.CHARLES ST B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore- Md
D STREET ADDRESS (If rural, give location)

23-V

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years—last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
FEMALE	WHITE	SINGLE.	SEPT 19th-1883	65	3	12

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SHOE SALESLADY	SHOES	BALTIMORE-MD	U S A

13. FATHER'S NAME: LEWIS HERMAN.

14. MOTHER'S MAIDEN NAME: BARBARA GOLDSMITH.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		JENNIE HERMAN	1055 S.CHARLES ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Occlusion	12/31/48
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Arterio. sclerosis & Hypertension	1940
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/12/ 1931, *to* 1/1/ 1949, *that I last saw the deceased alive on* 12/ 8, 1948, *and that death occurred at* 9 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Clem C. Judd M. D.	622 Wendover Road Balto 18	1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
BURIAL	JAN 4th49	OHEB SHALOM CEM	O'DONNELL ST

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
1/7/49	Emerson Williams, M.D.	J. AHRENS CO	2432 REISTERSTOWN RD

$5 1.00

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

94a

670070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 Hartford Ave
(c) Hospital or institution:

10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 Hartford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Loane

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-0978

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice I.
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Sept 22 1893

8. AGE: Years	Months	Days	If less than one day
55	3	7	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name Charles Loane
13. Birthplace Balto,

MOTHER
14. Maiden Name Theresa Bauer
15. Birthplace Balto

16 (a) Informant Alice I. Loane
(b) Address 1027 Hartford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 3 49 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4600 Belair Rd

18 (a) Funeral director Riggel Bros.
(b) Address 1800 E. Lombard St.

19 (a) 1/3/49 (Date rec'd by registrar) (b) Washington Hollidaysburg, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1948, at 8.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Dec 30 1948, and that I last saw h[illegible] alive on Dec 29 1948.

Immediate cause of death	Duration
Acute Hemorrhagic Pulmonary	5 min
Due to Pulmonary Tuberculosis	10 yr
Due to	
Other Conditions Tuberculous Ulcer	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Esta Stevens M. D.
Address 2818 Hartford Ave Date signed 1-3-49

VS 150

X

G70071 ✓ G70071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley La
(c) Hospital or institution:
Home For The Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Y
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 HOMEWOOD AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Mulcrone

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	212-12-6883	F	W.	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 1, 1882

8. AGE: Years	Months	Days	If less than one day
66	8	29/30	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name Michael Mulcrone
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name Jennie Cuskey
15. Birthplace BALTIMORE

16 (a) Informant Lillie Lukes The Poor
(b) Address 1200 Valley La

17 (a) BURIAL (b) Date thereof JAN 3 1949
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST PETERS
Location 1300 MORELAND AVE

18 (a) Funeral director DIPPEL BROS
(b) Address 1800 E LOMBARD ST.

19 (a) 1/2/49 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1948, at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1948 to Dec 31 1948, and that I last saw her alive on Dec 30 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Arterio Sclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 12/31/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6700.2 ✓ 6700.2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

74B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St.& Rutland Ave.
(c) Hospital or institution:
SINAI HOSPITAL. 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 10½ Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4305 Groveland Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE Tiefenthal, M.D. (GEORGE TIEFENTHAL)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of ~~husband or~~ wife Elizabeth Tiefenthal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1880.

8. AGE: Years	Months	Days	If less than one day
68	7	2	hr. min.

9. Birthplace Germany.
(Town, county, and state)
10. Usual Occupation Physician.
11. Industry or business

FATHER
12. Name Emanuel Tiefenthal,
13. Birthplace Germany.

MOTHER
14. Maiden Name Ernestina Heymann,
15. Birthplace Germany.

16 (a) Informant Mrs. Elizabeth Tiefenthal,
(b) Address 4305 Groveland Ave.

17 (a) Cremation (b) Date thereof 1/3/49.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Balto. Md.

18 (a) Funeral dir. Baird Lemmon & Lem
(b) Address 1902 Eutaw Place.

19 (a) 1/7/49 (b) Arthur Williams Registrar
(Date rec'd by registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1948, at 12 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1948, to 12/31 1948 and that I last saw him alive on 12/31 1948.

Immediate cause of death Aleukemic Leukemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Tepper MD M.D.
Address Sinai Hospital Date signed 1/3/49

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6700-73

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6700-73

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Pulaski Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NATHAN LIPMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Dora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Maryam
15. Birthplace Russia

16 (a) Informant Samuel Lipman
(b) Address 2627 Quantico Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-49 (month) (day) (year)
(c) Cemetery or crematory Herrlw Herring Run
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2426 Eutaw Place

19 (a) 1/2/49 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1948, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21 1948 to 12-31 1948 and that I last saw h[illegible] alive on 12-31 1948.

Immediate cause of death Coronary sclerosis Adam-Stokes — Duration

Due to

Due to

Other Conditions Cerebral arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 12-31-49

VS 150

X

G700.4 | BALTIMORE CITY HEALTH DEPARTMENT | 334.0 | G700.4

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 438 Pimlico Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Kessel Filtz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Aaron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1878

8. AGE: Years 70 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morris Kessel

13. Birthplace Lith

MOTHER 14. Maiden Name Tobee

15. Birthplace Lith

16 (a) Informant Aaron Filtz

(b) Address 438 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-49 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run

Location

18 (a) Funeral director Jacob Lewis Inc

(b) Address 2400 Eastern Place

19 (a) 1/3/49 (Date rec'd by registrar) Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 2 - 1949, at 6:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1949, to 1-2-1949, and that I last saw her alive on 1-2-1949.

Immediate cause of death Cerebrovascular accident — Duration

Due to Arteriosclerosis, cerebral & generalized.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address Sinai Hospital Date signed 1-2-49 M. D.

83a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70075 — 420.1 — 670075

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. G70075 — Registered No. 670075

1. NAME OF DECEASED (Type or Print): ANNA RANKIN
2. DATE OF DEATH: 1-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1816 Morland Ave
C. Length of stay in Baltimore: 38 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1816 Morland Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Russia	

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Harry Rankin	1816 Morland Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	
DUE TO (B)	Arteriosclerosis	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 19 46 *to* Jan 1 19 49, *that I last saw the deceased alive on* Jan 1, 19 49, *and that death occurred at* 12 30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
N. L. Keedle M.D.	3314 W. North Ave	1-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-3-49	Hebrew Young Men	Woodson Mill Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
1/2/49	Livingston Williams M.D.	Jack Levin Inc	2100 Eutaw Place

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CORRECTION 1-19-49

G700.6

✓ A20.1 G700.6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HERMAN GLANZMAN

2. DATE OF DEATH: 1-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3900 Eastern Ave
c. Length of stay in Baltimore: 19 Yrs. Mos. Days.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3900 Eastern Ave 26-9

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married		54 (52)		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant	Shoe	Newyork, N.Y	

13. FATHER'S NAME: Abraham Glauzman

14. MOTHER'S MAIDEN NAME: Ida

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Ida Glauzman ADDRESS: 3900 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 1946 *to* Nov Dec 19 48 *that I last saw the deceased alive on* 12/15 ; 19 48 *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles Flom M. D.

23B. ADDRESS: 312 3 Eutaw St

23C. DATE SIGNED: 1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/2/49

24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: 1/2/49

REGISTRAR'S SIGNATURE: (Huntington Williams, M.D.)

25. FUNERAL DIRECTOR: Jack Levinson ADDRESS: 2100 Eutaw Place

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G700.7 | BALTIMORE CITY HEALTH DEPARTMENT | G700.7

CERTIFICATE OF DEATH

937 | Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 Latrobe Park Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Latrobe Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Ziegler

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-07-7862

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30, 1885

8. AGE: Years	Months	Days	If less than one day
63	1		hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation Electric Railroad Worker

11. Industry or business Conductor

FATHER
12. Name Geo. Ziegler
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Yackel
15. Birthplace Maryland

16 (a) Informant Mary Ziegler (wife)
(b) Address 1504 Latrobe Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3-48 (Month) (Day) (Year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn Park, Md.

18 (a) Funeral director John R. Kemp
(b) Address Glen Burnie, Md.

19 (a) 1/3/49 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Dec. 1948, at 2:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, D. M.D. Medical Examiner.
Date signed 30 Dec. 48

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G700.8 ✓ G700.8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 E. Madison Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 E. Madison Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ANTONIA BUSINSKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Frank Businsky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 7, 1857

8. AGE: Years	Months	Days	If less than one day
91	7	22	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Czech.

MOTHER
14. Maiden Name unknown
15 Birthplace Czech.

16 (a) Informant Charles Businsky - son
(b) Address 2107 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location 4456 Belair rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison St. Balto. Md.

19 (a) 1/2/49 (Date rec'd by registrar) (b) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1948 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1948 to Dec 29 1948. and that I last saw her alive on Dec 29 1948

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny

Address 2200 E Madison St Date signed 12/31/48

X

Kunsby 6700.9 ✓ 331.0 6700.9

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or ~~institution~~: University of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County York
(c) City or town Windsor (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 E. Main St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Nora Ellen Kaisely

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed or divorced~~
F	W	Married

6 (b) Name of husband or wife Jacob Kaisely
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 17, 1892

8. AGE: Years	Months	Days	If less than one day
56	6	14	..... hr. ..... min.

9. Birthplace York, Pa. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

MOTHER / FATHER
12. Name Eli E. Snyder
13. Birthplace York, Pa.
14. Maiden Name Annie Mease
15. Birthplace Windsor, Pa.

16 (a) Informant Bruce Kaisely
(b) Address 614 Baldwin St. Balto, Md.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 1-4-49 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Windsor
Location York Co., Pa.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) 1/7/49 (Date rec'd by registrar) (b) ~~Huntington~~ Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Jan 1949, at 1 ~~P.~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Dec 1948, to 1 Jan 1949 and that I last saw h er alive on 1 Jan 1949

Immediate cause of death Respiratory failure — Duration 30 Min

Due to Increased intra-cranial pressure — 1 day

Due to Hemorrhage into left cerebellar hemisphere

Other Conditions Meniere's Syndrome Rt — 8 Years

(Include pregnancy within 3 months of death)

Date of operation 31 Dec. 48

Major findings of operation: Exploration Hemorrhage into the posterior fossa

of autopsy: Yes – Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature George A. Smith M. D.
Address 1 Jan 49 Date signed

83a University Hospital Baltimore Md.

G70080 BALTIMORE CITY HEALTH DEPARTMENT G70080
CERTIFICATE OF DEATH 61
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5309 Wesley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5309 Wesley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PAULINE A. DOTHE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife Frank H. Dothe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1878

8. AGE: Years	Months	Days	If less than one day
70	0	27	hr. min.

9. Birthplace Cincinnati, Ohio (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. H. C. Praetorius
(b) Address 5309 Wesley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1/4/49 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1948, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1948 to Dec 30 1948, and that I last saw h alive on Dec 30 1948.

Immediate cause of death Uraemia —
Due to Chronic Nephritis
also Diabetes Mellitus.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 2 mos. several yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Bernard Hood M. D.
Address 2200 Garrison Blvd Date signed 12/31/48

G70084 ✓ G70084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or ~~institution~~: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3630 Manchester Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tighe, Alice (LAURA)

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex F | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed~~ or divorced. Married

6 (b) Name of husband or ~~wife~~ Rudolph E. Tighe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1895

8. AGE: Years 53 | Months 3 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry J. Birie
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Isabelle McCoy
15. Birthplace Balto., Md.

16 (a) Informant Rudolph E. Tighe
(b) Address 3630 Manchester Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-49 (month) (day) (year)
(c) Cemetery or ~~crematory~~ New Cathedral
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) 1/2/49 (Date rec'd by local registrar) (b) Fort Williams, Md. Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 19 49 at 9 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 19 48 to 12-31 19 48; and that I last saw h[illegible] alive on 12-31 19 48.

Immediate cause of death Cerebral embolus (with R. hemiplegia) — Duration 3 days

Due to Rheumatic heart disease with mitral stenosis, auricular fibrillation, auricular thrombi, mild decompensation — Duration unknown

Due to ... — Duration ...

Other Conditions Arteriosclerosis, generalized

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Warren H. Davis M. D.
Address West Balto. Gen. Hosp. Date signed 12-31-48

#7#3E 670082 ✓ 199 670082

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Shirley Robinson

2. DATE OF DEATH: JAN 1 - 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Talbot
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Easton
D. STREET ADDRESS (If rural, give location):

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Single	12-3-40	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Earle A. Robinson

14. MOTHER'S MAIDEN NAME: Bessie Spencer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: approx. 1½ yrs.
DUE TO
(B) neuroblastoma with hypertension.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
April, 1948 approx.	Neuroblastoma of left kidney, adrenal, & spleen.	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE? (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-26-, 1948, *to* 1-1-, 1949 *that I last saw the deceased alive on* 1-1-, 1949, *and that death occurred at* 6.25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P. H. Hauser M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jany 5-'49	Spring Hill	Easton, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
1/2/49	Huntington Williams, M.D.	John A. Mitchell & Son	1901 Eutaw

VS 190

52a

G700853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G700853
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave.
(c) Hospital or institution:
St. Agnes Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 S. Rock Glen Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard F. Nolan

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Estelle E. Nolan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/12/96

8. AGE: Years	Months	Days	If less than one day
52	3	18	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Pressman
11. Industry or business Government Printing Office

FATHER
12. Name Michael Nolan
13. Birthplace Md

MOTHER
14. Maiden Name Mary O'Sullivan
15. Birthplace Ireland

16 (a) Informant Mrs. Estelle Nolan
(b) Address 205 S. Rock Glen Rd.

17 (a) Burial (b) Date thereof Jan 3 1949
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Natl. Cem.
Location Balto. Md.

18 (a) Funeral director Edw. A. MacNabb
(b) Address Towsonville 28.

19 (a) JAN 3 1949 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30/ 1948, at 4:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1948 to 12-30 1948, and that I last saw him alive on 12-30 1948.

	Duration
Immediate cause of death Respiratory failure -	
Severe diabetic acidosis	
Due to & coma	
Due to Acute hemorrhagic Pancreatitis	
Other Conditions Chronic cholecystitis & cholelithiasis	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney Johnson Venable M.D.
M. D.
Address St. Agnes Hospital Date signed 12-30-48

VS 193

X

700884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G700884

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1441 Henry St
(c) Hospital or institution: 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 1441 Henry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Agnes Dulaney

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-2950

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: George E. Dulaney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14th 1895

8. AGE: Years	Months	Days	If less than one day
53	11	16	hr. min.

9. Birthplace Annapolis Md. (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Victor Underwear Co.

FATHER
12. Name John R. Freeman
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth T. Colburn
15. Birthplace Md.

16 (a) Informant George E. Dulaney
(b) Address 1444 Henry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3rd 1949 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (d) JAN 3 1949 (Date rec'd by registrar) (e) [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30th 1948 at 9:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1948 to Dec 30 1948 and that I last saw h[illegible] alive on Dec 29 1948.

Immediate cause of death: Coronary Thrombosis — Duration

Due to:

Due to:

Other Conditions: Arteriosclerosis - hypertension

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Schaumel M. D.
Address 1337 S. Charles St Date signed 12/31/48

VS 150

X

70085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

Registered No. 70085

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution:
St. Agnes 28 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) ~~City or town~~ 4607 Manordene Rd
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Wachlin

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-05-1538

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Margaret Wachlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5/17/82

8. AGE: Years	Months	Days	If less than one day
66	7 6	9 13	hr. min.

9. Birthplace New Jersey (town, county, and state)
10. Usual Occupation Maintenance man
11. Industry or business Upland

FATHER
12. Name Herman Wachlin
13. Birthplace Germany

MOTHER
14. Maiden Name Julia Kelly
15. Birthplace Ireland

16 (a) Informant St. Agnes Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Janu. 3rd 1949 (month) (day) (year)
(c) Cemetery ~~Mount~~ New Cathedral
Location Old Frederick Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 322 S. High St.

19 JAN 3 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30/1948, at 1:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1948 to 12/30 1948.
And that I last saw h[illegible] alive on 12-30 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Arteriosclerotic ~~et~~ heart disease & diabetes	
Due to aneurysm of abd. aorta & ruptured (extra peritoneal)	
Other Conditions ~~of~~ terminal uremia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Johnson Jr. M.D.
Address St. Agnes Hospital Date signed 12-30-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6700-36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

6700-36 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 Warner Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES THAXTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name John Thaxton
13. Birthplace Va.

MOTHER
14. Maiden Name —
15. Birthplace Va.

16 (a) Informant Virlo Thaxton
(b) Address 760 Leonard Ave. Ft. Richmond, N.Y.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1 3 1949 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director Walter B. Lynch
(b) Address 1839 W. Hamburg St.

19 JAN 3 1949 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1948, at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cirrhosis of liver.
Ruptured oesophageal varices, with massive hemorrhage into stomach

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/30/48

VS 151

70087

GM. 80682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G70087 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aloysius Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W.

6 (b) Name of husband or wife Ozella (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 16 - 1882

8. AGE: Years	Months	Days	If less than one day
66	1	15	hr. min.

9. Birthplace MD,
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Arthur
13. Birthplace MD,

MOTHER
14. Maiden Name Francis Zinser
15. Birthplace MD,

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/49 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St

18 (a) Funeral director Lilly & Zeigler
(b) Address 403 S. Adolph St

19 JAN 3 1949 (Date rec'd by Registrar) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 12- 31 - 1948 at 6.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 31-1943 to 12- 31-1948. and that I last saw h alive on 12- 31-1948

Immediate cause of death
BRONCHOPNEUMONIA — 5 DAYS
PULMONARY EDEMA — 5 DAYS
Due to PULMONARY EMPHYSEMA — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: NONE
of autopsy: AS ABOVE

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jennings M. D.
Address BALTIMORE CITY HOSP. Date signed 1-1-49

VS 153

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 670048

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 425 North Rose Street

(c) Hospital or institution: 1-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town) 600 S. Curley Street

(d) Street No. (If rural give location)

(e) Citizen of foreign country? none (Yes or No)

If yes, name country

3 (a) FULL NAME Angelina Scandora

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marion Scandora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/27/99

8. AGE: Years 49 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Vincent Priozzi

13. Birthplace Italy

MOTHER

14. Maiden Name Emma / ?

15. Birthplace Sweden

16 (a) Informant Franes Scandora

(b) Address 600 S. Curley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 / 3 / 49 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Avenue

18 (a) Funeral director Lilly & Zeiler, Inc.

(b) Address 403 S. Wolfe Street

19 JAN 3 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/ 30 / 1948, at 3:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1947 to Dec 1948; and that I last saw h[illegible] alive on 12/23 1948.

Immediate cause of death Hypostatic Congestion

Cardio-vascular disease

Acute myocardial failure

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles F Corn M.D.

Address 3123 Eastern Ave Date signed 1/3/49

VS 150

Charles F Corn

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(0089

BALTIMORE CITY HEALTH DEPARTMENT 153 G70089

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address - Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 S. Newkirk St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mamie Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Thomas E. Simmons
6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr) August 15 1883

8. AGE: Years	Months	Days	If less than one day
65	4	16	hr. min.

9. Birthplace Baltimore Md (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Ward
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Zile
15. Birthplace

16 (a) Informant Thomas E. Simmons
(b) Address 528 S. Newkirk St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/49 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Clayton Ave East.

18 (a) Funeral director Lilly & Zeller Inc
(b) Address 403 S. Broadway

19 (a) JAN 3 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1 1949 at 3:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1948 to 1/1 1949 and that I last saw her alive on 1/1 1949.

Immediate cause of death	Duration
Cardiac failure	
Coasting, Obstruction Jaundice,	
Metastatic Ca. Liver	
Due to Carcinoma Cervix	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr W Hunter M.D.
Address Church Home Date signed 1/1/49

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

46E

70090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 70090

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Calhoun Sts

(c) Hospital or institution: Franklin Square Hosp. 9-9

(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 21

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1424 E. Lanvale St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Schutz (BARBARA SCHUTZ)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, ~~widowed~~, or divorced.

6 (b) Name of husband or wife: Michael Schutz- D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 12, 1866

8. AGE: Years: 82 | Months: 7 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER

12. Name: Paulus Popp

13. Birthplace: Germany

MOTHER

14. Maiden Name: ?

15. Birthplace: Germany

16 (a) Informant: Mr. John Schutz

(b) Address: 1424 E. Lanvale Street-13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/3/49 (month) (day) (year)

(c) Cemetery or crematory: Baltimore Cemetery

Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.

(b) Address: NORTH AVE. & BROADWAY

19 (a) JAN 3 1949 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31 1948, at 6.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1948, to 12/31 1948, and that I last saw her alive on 12/31 1948.

	Duration
Immediate cause of death: Subacute Lymphatic Leukemia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Bobby L. Jones M. D.

Address: Franklin Square Hosp. Date signed 12/31/48

X

VS 133

70091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 70091

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1207 E. North Avenue
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 E. North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HANNAH E. M. OEHME

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	None	F	W	Widow

6 (b) Name of husband or wife Henry L. Oehme -D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 8, 1857

8. AGE: Years	Months	Days	If less than one day
91	1	22	hr. min.

9. Birthplace Harford County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Shertzer
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Maryland

16 (a) Informant Mr. Herbert L. Oehme
(b) Address 1207 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)
(c) Cemetery or crematory Churchville Cem
Location Churchville, Md. Harford Co.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVENUE & BROADWAY

19 (a) JAN 3 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH December 30 19 48 at 7.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946 to Dec 30 1948, and that I last saw h alive on Dec 29 1948.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease -	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Sol Smith.
Address 1223 E North Ave Date signed 1/1/49 M. D.

VS 150

0092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 12B

Registered No. 700092

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6804 Fait Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6804 Fait Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES WILLIAM MILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	218-14-7643	M	W	Widower

6 (b) Name of husband or wife Julia C. - D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/23/1899

8. AGE: Years	Months	Days	If less than one day
65	9	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Filling Station

FATHER
12. Name Joseph H. Miller
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Eleanora Lilley
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Melva Miller
(b) Address 6804 Fait Avenue -24

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/49 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 3 1949 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1948 at 11.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1948 to Dec 31 1948 and that I last saw him alive on Dec. 31 1948.

Immediate cause of death Acute dilatation of the heart — Duration 2 days

Due to

Due to

Other Conditions Pulmonary tuberculosis active (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. D. Schwalka M. D.
Address 1001 Dundalk Av, Date signed 1/1/49

VS 150

95c

70093

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 70093

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 N. Eutaw Place Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CLARENCE E. TRACEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-0237

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret E. Tracey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 28, 1910

8. AGE: Years 38 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Bus Driver

11. Industry or business

FATHER
12. Name: Pleasant S. Tracey
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Ida B. Wilson
15. Birthplace: Maryland

16 (a) Informant: Margaret E. Tracey
(b) Address: 1112 N. Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1949 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cemetery
Location

18 (a) Funeral director: AUSTIN E. DONOVAN
(b) Address: 3638 Roland Avenue

19 JAN 3 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 1948, at 1:35 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary artery disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George G. Merrill M.D.
Medical Examiner.

Date signed 12-30-48

G70094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G70094 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY C. HECKER

2. DATE OF DEATH: Dec. 31st, 1948

3. PLACE OF DEATH: A. Baltimore City, Maryland 5216 Biddison Lane

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5216 Biddison Lane 27-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
female	white	widowed	Sept. 28, 1868	80	3	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Balto., Md.	U.S.A.

13. FATHER'S NAME: Adam M. Hecker

14. MOTHER'S MAIDEN NAME: Gertrude Brooms

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	none	Mrs. Margaret Smith, 5216 Biddison Lane

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7days

DUE TO

(B) Malignant Hypertension

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 29, 1947 *to* Dec 3, 1948 *that I last saw the deceased alive on* Dec 30, 1948, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. V. Harbold M. D.	4706 Harford Road	1-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	Jan. 3, 1949	St. Pauls Cemetery	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 3 1949	Huntington Williams, M.D.	Loraine Funeral Home	7401 BelairRd.

VS 150

70095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 70095

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3307 ELGIN AVE.
(c) Hospital or institution:
15 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 Elgin Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMOS EDGAR SPIELMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of husband or wife Linda M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 2, 1868

8. AGE: Years	Months	Days	If less than one day
80	10	29	hr. min.

9. Birthplace Hagerstown, Md.
(Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Amos Spielman
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Katherine McCoy
15. Birthplace Wash. Co., Md.

16 (a) Informant Miss Marion Spielman
(b) Address 3307 Elgin Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1-3-49 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 JAN 3 1949 (Date rec'd by registrar) at Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1948, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1948 to 12/31 1948, and that I last saw him alive on 12/29 1948.

Immediate cause of death	Duration
Carcinoma of intestine & metastasis to liver	18 mo.
Due to Cerebral hemorrhage	1 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Reiter, M. D.
Address 3408 Windsor Ave. Date signed 1/2/49

VS 150

X

G70036

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 Registered No. G70036

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice May Roth

2. DATE OF DEATH: Dec. 31, 1948

3. PLACE OF DEATH:
A. Baltimore City, Maryland
3708 Clipper Road
(If not in hospital or institution, give street address or location)

B. FULL NAME OF HOSPITAL OR INSTITUTION

c. Length of stay in Baltimore: 55 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3708 Clipper Road 12-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Nov. 10, 1876	72	1	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Joseph Roth
14. MOTHER'S MAIDEN NAME: Margaret Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: Noah E. Roth ADDRESS: 3708 Cipper Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 Hrs.
DUE TO
(B) Arteriosclerotic C.V. Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 15, 1948 *to* Jan. 1, 1949 *that I last saw the deceased alive on* Dec. 18, 1948, *and that death occurred at* 3:00 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Edward L. Glassman M. D.
23B. ADDRESS: 4037 Falls Rd.
23C. DATE SIGNED: 1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 3, 1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Burgee Funeral Home 3631 Falls Road

VS 150

G70037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70037 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry C. Weber

2. DATE OF DEATH: 1/1/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk Md

D. STREET ADDRESS (If rural, give location): 2209 Edgewater Ave

E. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto City Hospital

e. Length of stay in Baltimore: Yrs. 26 Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last Birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Single	June 25, 1893	[redacted] 55	7	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
assemblyman	Chev. Plant	Baltimore	

13. FATHER'S NAME: Louis Weber

14. MOTHER'S MAIDEN NAME: Anna Bosman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	War 1		Mrs. Lillian Weber	6723 Oak Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 420.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE C. P. Lehmkuhl M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/4/49	1st Evan. Luthern	O'Donnell St.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Clarence F. Hoffmann 1639 Broadway

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

94a

00-98

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. C700-98

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 622 N. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES CHAUMONT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Florence L. Glass
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 6, 1880

8. AGE: Years	Months	Days	If less than one day
68	9	25	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business Lloyd Mitchell

FATHER
12. Name Albert
13. Birthplace Germany

MOTHER
14. Maiden Name Bertrand
15. Birthplace Germany

16 (a) Informant Mrs. Florence L. Chaumont
(b) Address 622 N. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) JAN 3 1949 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 19 48 at 7 A. M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/31/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. G70059

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 N. Pearl St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N. Pearl St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Clifton R. Ridgeley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex male | 5. Color or race col | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Nora Ridgeley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 51 | Months 9 mos | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Orderly

11. Industry or business Hospital J.H.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Harriet Ridgeley
15. Birthplace Baltimore

16 (a) Informant Minnie Rose
(b) Address 506 N. Pearl Street

17 (a) Burial (b) Date thereof Jan 5 1949
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory MX C Burial
Location

18 (a) Funeral director C. Halstead
(b) Address 2 Druid Hill Ave

19 (a) JAN 5 1949 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1st 1949, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1948 to Jan 1, 1949. and that I last saw h[illegible] alive on Dec 30 1948.

Immediate cause of death Cerebral Hemorrhage (Intracranial Congestion) Dec 24, 1948

Duration

Due to

Due to

Other Conditions Bronchitis yr

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury 83a

23. Signature M. B. Tavana M. D.
Address 426 N. Wolfe St Date signed 1/1/1949

Affirmed before Deputy Examiner - Emil K. Hagen M.D.

VS 2

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70.00 180 G70.00

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 128 S. Monastary Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter A. Litzau

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine R. Litzau
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 15, 1888

8. AGE: Years	Months	Days	If less than one day
61	1	17	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Western Md. Dairy

FATHER
12. Name Julius Litzau
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Schaeb
15. Birthplace Germany

16 (a) Informant Mrs Katherine Litzau
(b) Address 128 S Monastery Ave

17 (a) Burial (b) Date thereof 1-5-49
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3501 Frederick ave

18 (a) Funeral director Harry H Wirtzke
(b) Address 4101 Edmondson Ave.

19 (a) JAN 3 1949 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1949, at 6 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1948, to 1-2 1949.
and that I last saw h alive on 1/2 1949.

Immediate cause of death CARDIO-RESPIRATORY FAILURE

Due to HYPERTENSIVE CARDIO-VASCULAR RENAL DISEASE

Due to CHRONIC NEPHROSCLEROSIS

TUMOR LEFT KIDNEY

Other Conditions TERMINAL UREMIA

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Shaw M. D.
Address St. Agnes Hosp Date signed 1/3/49

VS 153

52a

670:01

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 670:01

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SAMUEL GOLDSTEIN

2. DATE OF DEATH: 1-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 839 East Lombard St

C. Length of stay in Baltimore: 44 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 839 East Lombard St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	married	1-9-[illegible]	77				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bloak Maker		Poland	

13. FATHER'S NAME: Morris Goldstein

14. MOTHER'S MAIDEN NAME: Ida

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		Sophie Goldstein	893 E Lombard St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 420.0

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-vascular Disease
DUE TO ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1948 *to* Jan 3, 1949 *that I last saw the deceased alive on* Jan 2, 1949 *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. L. Grossman M. D.	1109 N. Calvert St	1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-3-49	B'Nai Israel	Northern Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 3 1949	Huntington Williams, M.D.	Jack Levin Inc	

VS 150

937

G70:02 at Sherman 125 South St G70:02

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALEXANDER MITCHELL

2. DATE OF DEATH: Jan. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1301 N. Charles St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1301 N. Charles St. 8-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Widower	Sept. 25, 1862	86	3 6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Police Officer	City of Baltimore	Constantinople, Turkey	U.S.

13. FATHER'S NAME: (Unknown) Mitchell

14. MOTHER'S MAIDEN NAME: Margaret (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		None	Carroll S. Mitchell	1702 E. 33rd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 422.2

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chron. Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

(B) Old age.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* March, 1948, to Dec 31, 1948, *that I last saw the deceased alive on* Dec 31, 1948, *and that death occurred at* 5 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Alfred S. Federmann M. D.	31 Preston Street	Jan 3 - 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/3/49	Green Mount	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 3 1949	Huntington Williams, M.D.	William Cook, Inc.	1217 St. Paul St.

VS 150

937

G70;03

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70;03 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CATHERINE ROBERTA MOONEY (Rebecca Mooney) (DJM)

2. DATE OF DEATH: 1/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 422 E. 25th St

B. FULL NAME OF ~~HOSPITAL OR INSTITUTION~~ (If not in hospital or institution, give street address or location): 422 E. 25th St

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 422 E. 25th 12-3

5. SEX	6. COLOR OR RACE	7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Widowed	2-4-76	72	10	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at Home	Easton Md	

13. FATHER'S NAME: (Unknown) Arringdale

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Frederick G. Freund	818 Winston Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 420.0

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C.V disease
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE: C. L. Lubrinski M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED: 1/2/49

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY OR ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	1/4/49	Woodlawn	Woodlawn, Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 3 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 151

93D

70:04

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

Registered No. 70:04

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 East 25th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME George H. Dasch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 27th 1866

8. AGE: Years	Months	Days	If less than one day
82	0	5	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Brass Molder

FATHER
12. Name Adam Dasch
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Lentz
15. Birthplace "

16 (a) Informant Mrs. Mildred Owings
(b) Address 2009 Boone St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) JAN 3 1949 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1949 at 6:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1948 to 1/2 1949 and that I last saw h~~im~~ alive on 1/2 1949.

Immediate cause of death	Duration
Cardio-respiratory failure	6 hrs.
Due to Cerebral hemorrhage	4 days
Due to cerebral arteriosclerosis?	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Md. Gen'l. Hosp. Date signed 1/2/49

830

VS 180

G70:05

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70:05

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Richard B. Hamilton

2. DATE OF DEATH: 3:18 A.M. Jan 1, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 429 E. 22nd St.
c. Length of stay in Baltimore: 71 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 429 E. 22nd St. 12-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	W.	Jan 22 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James B. Hamilton
14. MOTHER'S MAIDEN NAME: Mary Jane Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. G. Gerard Hamilton ADDRESS: 429 E. 22nd St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 443

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular Hypertension of Brain — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Acute Cardiac Dilatation — 1 day

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 24, 1948 *to* Jan 1, 1949 *that I last saw the deceased alive on* Jan 1, 1949 *and that death occurred at* 3:18 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: T. Hood Brindley M. D.
23B. ADDRESS: 600 Mallory Bldg
23C. DATE SIGNED: 1-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 4, 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Loring Byers ADDRESS: 5005 Park Heights Ave

VS 150

93D

Accident Room
Med Exam Case

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

H20.1 G70106 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Sorenson -
2. DATE OF DEATH: Jan 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 45 years

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1703 S Rutland Ave - 8-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	Oct 15 1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sexton St Church		Denmark	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Otto Sorenson Denmark	Ada Virginia Lee Denmark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	No	None	Records	JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteriosclerotic Cardiovascular Disease	?
DUE TO (B)	Incarcerated Epigastric Hernia	4 hours
DUE TO (C)	? Coronary Thrombosis	4-6 hours
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
	None	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None	None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

CERTIFICATION APPROVED BY
George L. Mesic M. D.
CHIEF OR ASST. MEDICAL EXAMINER

22. *I hereby certify that I attended the deceased from* Jan. 1, 1949 *to* ____, 19__, *that I last saw the deceased alive on* Jan 1, 1949, *and that death occurred at* 1 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Clark L. Wood Jr. M. D.	JOHNS HOPKINS HOSPITAL	1 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-4-49	London Park Cemetery	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 3 1949	Huntington Williams M.D.	Albert L. Hilt Jr	1606 N Chester St

VS 150

For Use Approved by Medical Examiner

93

Dr. Golley

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 670:07

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Pineridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6005 Sefton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella Sanders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Alfred Sanders
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1881

8. AGE: Years	Months	Days	If less than one day
67	3	17	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Albert Raine
13. Birthplace Md.

MOTHER
14. Maiden Name Minnie ?
15. Birthplace Md.

16 (a) Informant Mr. Alfred Sanders
(b) Address 6005 Sefton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-49 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5805 Harford Road #14

19 (a) JAN 3 1949 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31st 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to 12/31 1948 and that I last saw h[illegible] alive on 12/31 1948.

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury KYLE W. GOLLEY

23. Signature Kyle Golley M. D.
Address 5703 Harford Rd. Date signed 12/31/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly

70:08 Dr. Colley
5103 Harford Road
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C70:08

1. NAME OF DECEASED (Type or Print): William H. Hippler

2. DATE OF DEATH: Jan. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5103 Richard Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 5103 Richard Avenue 27-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Sept. 3, 1879	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Martin Hippler
14. MOTHER'S MAIDEN NAME: Augusta Windoff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ?
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Wife, 5103 Richard Avenue
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 440

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertensive Cardio-Vascular Renal Disease	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10, 1949 *to* 1/2, 1949, *that I last saw the deceased alive on* 1/2, 1949, *and that death occurred at* 4:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Theresa Colley M. D.
23B. ADDRESS: 5102 Harford Rd
23C. DATE SIGNED: 1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 5, 1949	Loudon Park	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR / ADDRESS: Leonard J. Ruck, 5305 Harford Rd.

VS 150

937

67009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67009

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary E Harrison

2. DATE OF DEATH: 1/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 417 417 N. 24th St 417 N. 24th St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 415 W 23rd St 12-7

c. Length of stay in Baltimore: Yrs. / Mos. / Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F	W	W	2/21/1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Balto.	

13. FATHER'S NAME: Michael Mc Cann

14. MOTHER'S MAIDEN NAME: Louisa Hebb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Mr James F. Harrison - 415 N. 23rd St.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH 420.0

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C.V disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* _____ (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
D. P. Lankenau M.D.		1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-4-49	New Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 3 1949	Huntington Williams M.D.	Leonard J. Ruck	5305 Harford Rd

937

VS 151

G70110 ✓ G70110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 593

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dorothea E. Housman

2. DATE OF DEATH: Dec. 30, 1948

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2791 Tivoly Avenue

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2791 Tivoly Avenue 9-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	widowed	June 1, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore	

13. FATHER'S NAME: Henry L. Schmidt

14. MOTHER'S MAIDEN NAME: Susanna G. Guethe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mrs. Lydia Weaver, 2791 Tivoly Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Myocardial Insufficiency	2 weeks
DUE TO (B)	Arthritis, severe, generalized	21 years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1946 *to* 30 Dec, 1948, *that I last saw the deceased alive on* 30 Dec., 1948, *and that death occurred at* 9:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jos. M. Zeisemer M. D.	2054 Harford Rd.	2 Jan. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-3-49	Parkwood Cem.	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 3 1949	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

X

Dr. Moses
448 N. Luzerne St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

BIRTH NO.

Registered No. 6701.1

1. NAME OF DECEASED (Type or Print) **Annie Wartinger**

2. DATE OF DEATH **Dec. 30, 1948**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **620 N. Milton Avenue**

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore, Maryland**
D. STREET ADDRESS (If rural, give location) **620 N. Milton Avenue** 1-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Jan. 11, 1872	76	11 / 19	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **at home**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): **Germany**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: **Unknown**

14. MOTHER'S MAIDEN NAME: **Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — ADDRESS: **Mrs. Bernard Rohm, 620 N. Milton**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	2 hours
DUE TO (B)	Arteriosclerotic heart disease	2 years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/28, 1948, *to* 12/30, 1948, *that I last saw the deceased alive on* 12/30, 1948, *and that death occurred at* 12:15 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Helen B. Moses M. D.	448 N. Luzerne Ave	1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-3-49	Holy Redeemer	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 3 1949	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

70:12

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 70:12

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3614 Chesterfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3614 Chesterfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie G Lange

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife George Lang (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 18 1875

8. AGE: Years	Months	Days	If less than one day
73	2 3	13	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Geo Weedinger
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15 Birthplace

16 (a) Informant Mrs T H Keller
(b) Address 3614 Chesterfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3/49 (month) (day) (year)
(c) Cemetery or crematory First United Cem
Location Baltimore

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 JAN 3 1949 Huntington Williams, M.D. (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1948 at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 19 48 to Dec 31 19 48
and that I last saw h[illegible] alive on Dec 31 19 48

Immediate cause of death Coronary Thrombosis — Duration 2 Days

Due to Hypertension — Duration yrs

Due to Age — Duration years

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A Bailey M.D.
Address Chesapeake Bldg Date signed 12/31/48 M. D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

70:13

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

Registered No. G70:13

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Unknown
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM G. HOHMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1890

8. AGE: Years	Months	Days	If less than one day
58	7	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

FATHER
12. Name Henry J. Hohman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Marie Bauernschmidt
15. Birthplace Baltimore

16 (a) Informant Henry J. Hohman, Jr.
(b) Address 1608 E. 32nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3/49 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem
Location Balto Co Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2908 Orleans St

19 JAN 3 1949 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1948 3.29p M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute alcoholism

Due to

Other Conditions Amyl alcohol (denatured)

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed December 30, 1948

VS 151

X M.P.

70:14 ✓ G70:14

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ——
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Wilson St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Russ

3 (b) If veteran, name war: W.W. 2

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	M

6 (b) Name of husband or wife: Clara
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 9-22-19

8. AGE: Years	Months	Days	If less than one day
29	3	8	____ hr. ____ min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Teamster
11. Industry or business ?

FATHER
12. Name James Russ
13. Birthplace ?

MOTHER
14. Maiden Name Sara Corbin
15. Birthplace ?

16 (a) Informant Clara Russ
(b) Address Same Wife

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)
(c) Cemetery or crematory Balto Nat
Location md

18 (a) Funeral director George B. Nelson
(b) Address 1303 Eastman St

19 JAN 3 1949 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30-1948, at 11:18 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30-1948 to 12-30-1948 and that I last saw him alive on 12-30-1948.

Immediate cause of death	Duration
Acute forward heart failure	10 min
Due to Suspected shock	
Due to Rupt. Gall Bladder Gangrenous	6 days
Other Conditions Generalized peritonitis	

(Include pregnancy within 3 months of death)

Date of operation 12-25-48
Major findings of operation: Rupt gangrenous gall bladder
of autopsy:

PHYSICIAN
Underline the one to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allyn P. Jackson M. D.
Address Mercy Hospital Date signed 12-30-48

VS 150

170115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 1170115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1319 Madison Ave.
(c) Hospital or institution: Bare Hill - Ba Nursing Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1554 Leslie St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Jane Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife Chas.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1868

8. AGE: Years	Months	Days	If less than one day
80	7	7	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Basil Rhubottom
13. Birthplace Md.

MOTHER
14. Maiden Name Moriah ?
15. Birthplace Md.

16 (a) Informant Walter Williams
(b) Address 1854 Leslie St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/49 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St.

19 (a) JAN 3 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1948, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1948 to Dec 30 1948 and that I last saw her alive on Dec 30 1948.

Immediate cause of death: Cardio-Vascular Renal disease — Duration: 1 year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Jackson M. D.
Address 600 N. Arlington Ave Date signed 12-31-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

D:16

BALTIMORE CITY HEALTH DEPARTMENT 241 ✓ Registered No. 670:16

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 Brighton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓ 16

(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Brighton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Kazimeras Trapocka

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 212-01-2996

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 12th 1881

8. AGE: Years	Months	Days	If less than one day
67	3	21	20 hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Self

FATHER
12. Name John Trapocka
13. Birthplace Lithuania

MOTHER
14. Maiden Name Unknown
15. Birthplace Lithuania

16 (a) Informant Mrs Helen Trapocka
(b) Address 2808 Brighton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 (month) 5 (day) 49 (year)

(c) Cemetery or crematory Holy Redeemer
Location Kentucky Ave & Belair Rd

18 (a) Funeral director John J. Curran
(b) Address 901-03 Hollins St.

19 JAN 3 1949 (Date rec'd by State Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2nd 1949 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Jan 1949.
and that I last saw h~~im~~ alive on Dec 30 1948.

Immediate cause of death Heart failure (Duration)
Heart Decompensated

Due to Chronic Bronchial asthma

Due to

Other Conditions Terminal Pneumonia

(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W Wallace Wachs M. D.
Address 422 Med Arts Bldg Date signed Jan 3/49

VS 193

95c

670.17 ✓ 420.1 670.17

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1049 N Schroeder st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore 5 (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore ✓ (If outside city or town limits, write RURAL and give name)
(d) Street No. 1049 N Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Germany

3 (a) FULL NAME Mary Rambert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1895

8. AGE: Years	Months	Days	If less than one day
53	7	20	hr. min.

9. Birthplace Maysville So Carolina (Town, county, and state)
10. Usual Occupation Maid
11. Industry or business

FATHER
12. Name Reford young
13. Birthplace Summerville So Carolina

MOTHER
14. Maiden Name Clara Davis
15. Birthplace Maysville So Carolina

16 (a) Informant Mrs Hazel Thompson
(b) Address 1049 N Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6. 1949 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore city

18 (a) Funeral director Joseph A Bruch
(b) Address 66 West Baltimore Street

JAN 3 1949 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1 1949 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1948 to 1/1 1949
and that I last saw him alive on 1/1 1949

Immediate cause of death Coronary Arteriosclerosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben Roberts M.D.
Address City Hospital Date signed 1/3/49

VS 150

94a

70:18 ✓ 670:18

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 East North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 East North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NANNIE ELIZABETH LIDIE

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1874

8. AGE: Years	Months	Days	If less than one day
74	-	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name A.M.Cooper
13. Birthplace Bermudia

MOTHER
14. Maiden Name Rose Lorvell
15 Birthplace Frederick Md.

16 (a) Informant MR. HOWARD C. LIDIE
(b) Address 425 E. NORTH AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/49 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 JAN 3 1949 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1948, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1948 to 12-31 1948, and that I last saw her alive on 12-31 1948.

Immediate cause of death	Duration
Hypertension	2 yrs
Due to Cerebral Hemorrhage	24 hours
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. D. Flynn M. D.
Address 1 E. Chase St Date signed 1-3-49

VS 150

670:19

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

670:19

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) HARRY M. HANGER

2. DATE OF DEATH January 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto. General Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3000 Reisterstown Road 15-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		Nov. 2, 1910	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Auditor	U. S. Army	Washington, D. C.	—

13. FATHER'S NAME Harry H. Hanger

14. MOTHER'S MAIDEN NAME Mahlon Farris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Alma Hanger, 3000 Reisterstown Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 581.0

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of liver.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
		—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	—

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER [X] / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George L. Merrill M.D.		Jan. 3. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 5, 1949	~~George Washington Mem. Pk.~~ Georgetown Mem. Pk.	Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 3 1949	Huntington Williams, M.D.	W. W. Chambers, Wash. D. C.

VS 151

124B

smt

G70120

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70120

Registered No.

1. NAME OF DECEASED (Type or Print): MARY VIRGINIA CAMPBELL

2. DATE OF DEATH: Jan. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 34 York Court
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 34 York Court 12-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed		About 80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Md.	

13. FATHER'S NAME: Michael Dunn

14. MOTHER'S MAIDEN NAME: Susan Coulter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Thomas D. Campbell	34 York Court

MEDICAL CERTIFICATION

16. CAUSE OF DEATH 450.0

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1939 19__, *to* 1-1 , 1949 *that I last saw the deceased alive on* 12-31 1948 *and that death occurred at* 3:40 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
O. L. Ewald Jr. M. D.	340 York Ct.	1-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 4, 1949	Cathedral	Baltimore, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 3 1949	Huntington Williams, M.D.	H. H. Mears and Son.	805 N. Calvert St.

VS 150

97

70:21

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 70:21

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 433 Hutchins Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Hutchins Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarke H. Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/27/878

8. AGE: Years 70 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte Young
15. Birthplace Maryland

16 (a) Informant Celeste Wilson
(b) Address 433 Hutchins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 (month) 3 (day) 49 (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson, Maryland

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 JAN 3 1949 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION 1948

20. DATE OF DEATH December 31 1947, at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1947 to Dec 31 1948, and that I last saw him alive on Sept. 7 1948.

Immediate cause of death Arteriosclerotic Heart disease — Duration 4 yrs
Due to Senility — 1 yr
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. S. Shadrick M.D.
Address 6210 York Rd. Date signed Dec 31, 48

VR 150

G70:22 BALTIMORE CITY HEALTH DEPARTMENT G70:22

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Will Simmons

2. DATE OF DEATH 1 Jan 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 804 St Paul St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 5 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 804 St Paul St 11-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months Days	If under 24 hours: Hours Min.
Male	White	Married	July 4 1884	64	5 28	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Etcher	Artist	Spain	

13. FATHER'S NAME Edward Simmons

14. MOTHER'S MAIDEN NAME Vesta Schallenberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
?		George B Simmons 137 Equitable Bldg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 420.9

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) A. S. C. J. D.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Kemp M.D.		2 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
CREMATION	Jan 3 1949	Green Mount.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 3 1949	Huntington Williams, M.D.	Henry W. Jenkins Sons Co	4905 York Rd.

937

VS 151

G70123 BALTIMORE CITY HEALTH DEPARTMENT G70123 t

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Louisa M. Koch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 Sept 1865

8. AGE: Years	Months	Days	If less than one day
93	3	28	hr. min.

9. Birthplace Baltimore md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Hiller
13. Birthplace Germany

MOTHER
14. Maiden Name Margret Steinlein
15. Birthplace Germany

16 (a) Informant George J. Koch
(b) Address 523 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4 49 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location

18 (a) Funeral director Charles P Towell
Address 2427 Edmondson Ave

19 (a) JAN 3 1949 (Date rec'd by registrar) Huntington Willis, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Dec. 1948, at 9:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Dec 1948 to 31 Dec 1948, and that I last saw h~~e~~r alive on 31 Dec 1948.

Immediate cause of death: Cardio-respiratory failure

Due to

Due to

Other Conditions Carcinoma ~~of~~ cervix, gen. debility

(Include pregnancy within 3 months of death)

Date of operation 31 Dec 1948

Major findings of operation: Ca of cervix & obstruction of ileum

of autopsy:

Duration
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M.T. McGarry M.D.
Address Maryland Gen. Hosp. Date signed 31 Dec 1948

VS 150

670124 ✓ 670124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 857 W. Lemond St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-3

(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 857 W. Lemond St. (If rural, give location.)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida. J. Hawkins (or Isabelle Hawkins)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
~~Female~~	Col.	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1892

8. AGE: Years	Months	Days	If less than one day
56	9	24	hr. min.

9. Birthplace West River Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unkown
13. Birthplace Unkown

MOTHER
14. Maiden Name Rose Moore
15. Birthplace West River Md

16 (a) Informant Rachel Lewis
(b) Address 857 W. Lemond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (mo.) Jan. (day) 5 (yr.) 1945

(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 (a) (Date rec'd) JAN 8 1945 (Registrar) Huntington Wellington, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30 1944, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1944 to 12/30 1944 and that I last saw him alive on 12/24 1944.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elroy O. Wilson M. D.
Address 1000 Brantly Ave. Date signed 12/30/44

×

Warning: WITH UNPLEASING INK. Entry, item of information should be entirely supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Asl 6 G70125 ✓ G70125

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): William McDonald

2. DATE OF DEATH: JAN 2 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1740 E Baltimore St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Widowed	1-6-64	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		West Va	

13. FATHER'S NAME: George Washington McDonald

14. MOTHER'S MAIDEN NAME: Elizabeth Joro

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 331

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral hemorrhage	18 hrs
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Arteriosclerosis and	
DUE TO		
	(C) Hypertension	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-2- , 1949, *to* 1-2- , 1949, *that I last saw the deceased alive on* 1-2- , 1949, *and that death occurred at* 6:15 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas D. Dinbergis M. D.	JOHNS HOPKINS HOSPITAL	1-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 6 - 1949	Green Hill cem.	Martinsburg West Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 3 1949	Huntington Williams, M.D.	Riggal Bros.	1800 E. Lombard St.

VS 150

83a

Dr. De Hoff Bal 6565
2020 N. Charles St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70126
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CATHERINE D. GODWIN
2. DATE OF DEATH Jan 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2004 McKean Ave.
c. Length of stay in Baltimore Yrs. 9 Mos. 7 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore City Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2004 Mc. Kean Ave 15-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 hours: Hours	Min.
Female	White	Married	May 6. 1861	87-	7	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) St. Marys Co. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Peacock
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Miss Catherine M. Godwin ADDRESS 2004 Mc Kean Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 170

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma R. Breast, — INTERVAL BETWEEN ONSET AND DEATH: Co yrs
DUE TO no other disease
(B) Gradually weakened
DUE TO after attack of Vomiting 3 days,
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* 1/1, 1949 *that I last saw the deceased alive on* 1/1, 1949 *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Wm. De Hoff M. D.
23B. ADDRESS 2020 N. Charles St
23C. DATE SIGNED 1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Tuesday Jan 4 1949.
24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem
24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 3 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Maurice Cook Syfes ADDRESS 1600 W. Pratt North

VS 150

50

B.C. H-28478 H-28478-79 ✓ G70127
G70127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) **Francis Lee Niser**

2. DATE OF DEATH **Jan. 1/49**

3. PLACE OF DEATH: A. Baltimore City, Maryland **1807 Dover St/**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Md.** B. COUNTY **Balto**

1807 Dover St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 19-4

c. Length of stay in Baltimore **Life** Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) **1807 Dover St/**

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	**White**	**Single**	**July 14,1945**	**3**	**5**	**17**		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Baltimore, Md.**

12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME **Parker Niser**

14. MOTHER'S MAIDEN NAME **Anna Tyler**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS **Parker Niser, 1807 Dover St.**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 491

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Bronchopneumonia** — INTERVAL BETWEEN ONSET AND DEATH: **36 hrs**

DUE TO

(B) **secondary anemia**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) **malnutrition**

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **spastic paraplegia**

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **May** *, 19* **46** *to* **1 Jan** *, 19* **49** *, that I last saw the deceased alive on* **31 Dec** *, 19* **48** *, and that death occurred at* **1:10A** *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H H Bayliss M. D.	**1600 Wiekens Ave**	**3 Jan 49**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**Jan. 4/49**	**Louden Park**	**3801 Frederick Rd. Balto. Md**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 3 1949	Huntington Williams, M.D.	Harry H. Nitzke	4101 Edmondson Ave.

VS 150

82

G70128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 141

G70128 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave & Dukeland
(c) Hospital or institution:
West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Margate (Brooklyn 25, Md.)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Northdale Road Box 291
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Cunningham

3 (b) If veteran, name war	3 (c) Social Security Account No. 213 09 8596

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Charlotte C. Cunningham
Nee Oliver 6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Apr. 31, 1902

8. AGE: Years	Months	Days	If less than one day
46	8	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Upholsterer
11. Industry or business Hecht Bros.

FATHER
12. Name Frank Cunningham
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Dolly Taylor
15. Birthplace Hollywood Prince George Co.

16 (a) Informant Mrs. Charlotte C Cunningham
(b) Address Margate, Brooklyn 25, Md. Box 291

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 4, 49 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) JAN 3 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1949, at 6.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1949 to Jan. 2 1949, and that I last saw him alive on Jan. 2 1949.

Immediate cause of death	Duration
Uremia	
Due to Carcinoma of Bladder	6 mos.
Due to	
Other Conditions Bilateral Hydro-nephrosis + Hydroureter	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel L. Silverstein
Address Asst Balto Gen Hosp Date signed 1/2/49

52B

G70129 X G70129

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Shirley McNeely

2. DATE OF DEATH 1 Jan 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1318 Bruden Ct

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE New York B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore Yrs. Mos. Days 2 Weeks

5. SEX Female

6. COLOR OR RACE C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH 1/31/47

9. AGE (In years last birthday) 1 — If Under 1 Year: Months 11, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Longsland N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Aron McNeely

14. MOTHER'S MAIDEN NAME Hellen Poise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Aron McNeely ADDRESS 1318 Bruden Ct

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 491

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy / Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L Rose M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 2 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1949 January 5th

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery

24D. LOCATION (City, town, or county) (State) B. C. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 3 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Robert E. Williams

ADDRESS 1515 McElderry St

VS 19 107

G70150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G70150 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs. 10 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Naturalized American (Yes or No)
If yes, name country Apr 23, 1926 - Baptist Bethel Baltimore

3 (a) FULL NAME Francis May

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1878

8. AGE: Years	Months	Days	If less than one day
70	7	7	hr. min.

9. Birthplace Liverpool, England
(Town, county and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James J May
13. Birthplace Belfast, Ireland

MOTHER
14. Maiden Name Rose C. McAdams
15. Birthplace Belfast, Ireland

16 (a) Informant Case history at Hospital
(b) Address 1000 Caton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/49 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director MARTIN FAHEY & SONS
(b) Address 1827 W. NORTH AVE.

19 (a) JAN 3 1949 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31/1948 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 12/30/1948.

Immediate cause of death CARDIAC RESPIRATORY FAILURE — Duration

Due to PNEUMONIA CEREBRAL HEMORRHAGE (OLD)

Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

Other Conditions AMPUTATED LEFT LEG.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Shaw M. D.
Address [illegible] Hospital Date signed 1/3/49

VS 150

BIRTH NO. 670131

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 670131

1. NAME OF DECEASED (Type or Print): Francis J. Pignataro Sr.

2. DATE OF DEATH: Jan. 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 938 E. Biddle St

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

c. Length of stay in Baltimore: 33 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Baltimore, Md; B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 938 E. Biddle St 10-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	Aug. 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Technician	Laboratory	New York	U. S.

13. FATHER'S NAME: Vincent Pignataro

14. MOTHER'S MAIDEN NAME: Josephine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No	219-16-8004	Francis Pignataro Jr. 1604 E. Federal St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 422.2

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 days --

DUE TO

(B) Chronic myocarditis + myocardial degeneration

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 26, 1947 *to* Jan 2, 1949, *that I last saw the deceased alive on* Nov. 25, 1948, *and that death occurred at* 1:15 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1500 E North Ave	Jan 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial more	Jan. 5, 1949	Baltimore	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 3 1949	Huntington Williams, M.D.	Rita Wiedefeld	900 E. Biddle St

VS 150

1500 E North Ave

937

G70132 BALTIMORE CITY HEALTH DEPARTMENT G.70132
CERTIFICATE OF DEATH 4/0 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Mulherin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Cath. Gutham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1878

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Michael Mulherin
13. Birthplace

MOTHER 14. Maiden Name Mariah Higgins
15 Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1949 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St

JAN 3 1949 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1949, at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1948 to Jan 2 1949 and that I last saw him alive on Jan 2 1949.

Immediate cause of death: Acute Dilatation Heart — Duration: 1 day
Due to: Mitral Stenosis — 5 yrs
Due to:
Other Conditions: Arteriosclerosis — 7 yrs
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E Gill Hall
Address 1631 E North Ave Date signed 1/3/49 M. D.

VS 150

92B

G70133

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70133

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles or Calogero Palmieri

2. DATE OF DEATH January 1st 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1913 Eutaw Place

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE B. COUNTY 3105 Wisteria Ave Baltimore Md.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twilight Rest and Nur. Home 1913 Eutaw Pl.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md.

c. Length of stay in Baltimore 40 Yrs. Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 27-44

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Widowed	March 20-1862	86	9 / 11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Villarosa Italy	Italy

13. FATHER'S NAME Vincenzo Palmieri

14. MOTHER'S MAIDEN NAME Maria Iannello

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Mrs. Daniel Douglas 3105 Wisteria Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

331

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral hemorrhage	
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 30, 1948, to Jan 1, 1949, *that I last saw the deceased alive on* Dec. 30, 1948, *and that death occurred at* 11:45 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. F. Cutterman M. D.	2324 Reisterstown Rd	Jan 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	January 4/49	Holy Redeemer Cemetery	Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 3 1949	Huntington Williams, M.D.	Frank Dellabosca 322 S. High St.

VS 150

83a

670134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

670134 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): NELLIE M. MORRIS

2. DATE OF DEATH: January 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4207 Anntana Avenue
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4207 Anntana Avenue 26-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	White	Married	March 21, 1903	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	USA

13. FATHER'S NAME: James Whalen

14. MOTHER'S MAIDEN NAME: Mellie M. Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Peter F. Morris	4207 Anntana Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Carcinoma of rectum c metastasis to liver 15H — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 1, 1948 *to* Jan 2, 1949 *that I last saw the deceased alive on* Jan 1, 1949 *and that death occurred at* 7:30 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1001 E. Fayette	1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	January 5, 1949	New Cathedral	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 3 1949	Huntington Williams, M.D.	M. F. Sadowski & Sons,	1808 Eastern Ave.

46D

G70135 ✓ G70135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Eutaw Pl.
(c) Hospital or institution:
Twilight Nursing Home 19-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 S. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. West

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1870

8. AGE: Years 78 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Martinsburg, W.Va.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph West
13. Birthplace W.Va.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1949 (month) (day) (year)
(c) Cemetery or crematory Greenhill
Location Martinsburg, W.Va.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31st 1948, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1948 to 12/31 1948.
and that I last saw him alive on 12/31 1948.

Immediate cause of death: chronic myocarditis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Futterman, M.D.

Address 7324 Reisterstown Rd. Date signed 1/1/49

VS 153

X

(2)

G70136 BALTIMORE CITY HEALTH DEPARTMENT ✓ G70136

CERTIFICATE OF DEATH 939

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 W. Lombard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Peach

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Edward Peach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1870

8. AGE: Years	Months	Days	If less than one day
78	3	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Charles H. Josenhans
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eleanor F. Snyder
15. Birthplace Baltimore, Md.

16 (a) Informant M. LeClara Peach
(b) Address 1505 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-49 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 (a) 1/3/49 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 31 1948, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Dec 1948
and that I last saw h alive on 19

Immediate cause of death: Arteriosclerotic cardiovascular disease — Duration: 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert H. Katz
Address 1020 Wilkens Ave Date signed 1/5/49 (M. D.)

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

BIRTH NO. G70137

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G70137 Registered No.

1. NAME OF DECEASED (Type or Print): Frank M. Neikirk

2. DATE OF DEATH: Jan. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2562 Harlem Ave.
c. Length of stay in Baltimore: 45 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2562 Harlem Avenue 16-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	Jan. 13, 1869	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Neikirk
14. MOTHER'S MAIDEN NAME: Sarah King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Jessie L.D.Neikirk ADDRESS: 2562 Harlem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 420.1

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	1 hr.
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)	Hemiplegia, old, left	2 yrs.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/4/49	Loudon Park Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 151

94a

Certificate Corrected 1-14-49.

G70138

BALTIMORE CITY HEALTH DEPARTMENT ✓ 420.1

CERTIFICATE OF DEATH

G70138 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Crofton Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27, 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Crofton Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN HAROLD ANDERSON

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ruth M. Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1892

8. AGE: Years	Months	Days	If less than one day
56	5	9	hr. min.

9. Birthplace Lahaye (La Haye) Ill.
(Town, county, and state)

10. Usual Occupation Marketing Specialist
11. Industry or business Dept. of Agriculture U.S.

FATHER
12. Name Alfred Anderson
13. Birthplace (Ill.) Kansas

MOTHER
14. Maiden Name Cora Warren
15. Birthplace (1320 Crofton Rd) LaHarpe, Ill.

16 (a) Informant Mrs. Henry Douglas
(b) Address 1320 Crofton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/49 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 3 1949 (Date rec'd by Registrar) (b) Harrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1949, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1943 to Jan. 1st 1949. and that I last saw h.s alive on Jan 1st 1949.

	Duration
Immediate cause of death Coronary Thrombosis	2 hours.
Due to Coronary arteriosclerosis	6 years
Due to Generalized arteriosclerosis	—
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury,

23. Signature Louis P. Hamburger Jr. M. D.
Address 1207 Eutaw Pl. Date signed 3 Jan '49

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

94a

670139 BALTIMORE CITY HEALTH DEPARTMENT ✓ 670139
CERTIFICATE OF DEATH
X 420.0 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 Roland Ave
(c) Hospital or institution: Rutledge Villa
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Littlestown
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie V. Elene

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife John W Elene
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 8 1859

8. AGE: Years	Months	Days	If less than one day
89	8	26½	hr. min.

9. Birthplace Littlestown Pa.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John H. Spaulding
13. Birthplace Littlestown Pa.

MOTHER
14. Maiden Name Jane Bankert
15. Birthplace Littlestown Pa.

16 (a) Informant Mrs. Gertrude Doll
(b) Address Frederick Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6-49 (month) (day) (year)
(c) Cemetery or crematory St Aloysius
Location Littlestown Pa.

18 (a) Funeral director J. F. Elene-Sons
(b) Address Westminster Md.

19 (a) JAN 3 1949 (b) Signature and title of registrar Clayton Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3rd 1949, at 3 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1940 to January 1949, and that I last saw her alive on January 2 1949

Immediate cause of death Arteriosclerotic Cardio-Vascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wellams J Helfrich

Address 506 Roland Ave Date signed 1-3-49

437

VS 185

#2H 4E G701-0 X ✓ 193 G701-0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Susan Marie Toohey

2. DATE OF DEATH: JAN 2 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Montana
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bozeman
D. STREET ADDRESS (If rural, give location): RR #3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Child	2-17-48		10			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Montana
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James Toohey
14. MOTHER'S MAIDEN NAME: Margaret Johns
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral haemorrhage
DUE TO
(B) Brain tumour
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Congenital heart disease

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION: 12.31.48
19B. MAJOR FINDINGS OF OPERATION: Cong. heart disease - transposition
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-16 1948 *to* 1-2 1949 *that I last saw the deceased alive on* 1-2 1949 *and that death occurred at* 10:38 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: a. c. Kang M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1.3.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Jan 4/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Bozeman Montana

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1949
REGISTRAR'S SIGNATURE: Williams, M.D.
25. FUNERAL DIRECTOR: Nelch Funeral Home
ADDRESS: 2008 Orleans St

VS 150

54a

G70141 ✓ G70141

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 N. Patterson Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHIA CATHERINE MURRAY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	separated

6 (b) Name of husband or ~~wife~~ Martin J. Murray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 11, 1879

8. AGE: Years	Months	Days	If less than one day
69	8	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John J. Snyder
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Fay
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Robert Halfpenny - aght.
(b) Address 924 N. Montford Ave.,

17 (a) Burial (b) Date thereof 1/4/49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Cross
Location Annapolis Blvd., Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison St. Balto. Md.

JAN 3 1949 (b)
(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1949 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1949 to Dec 31 1949 and that I last saw her alive on Dec. 28 1949.

Immediate cause of death	Duration
Acute Coronary Occlusion	4 hours
Due to Arteriosclerotic	
Due to Heart Disease	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Israel Kaen M.D.
M. D.
Address 2413 E Monument St
Diagnosed

1/3/49

G70142 BALTIMORE CITY HEALTH DEPARTMENT G70142

CERTIFICATE OF DEATH

420 D Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANNETTE PIERCE FOOS 2088

2. DATE OF DEATH JANUARY 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hosp.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1408 Poplar Grove Street 16-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widowed	Oct. 16, 1880	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	

13. FATHER'S NAME Edward A. Rutter

14. MOTHER'S MAIDEN NAME Katherine Lynch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			John Foos, son	4302 Stanwood Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Jan. 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/6/49	Holy Redeemer	4430 Belair Rd., Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 3 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS
Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St., Balto. Md.

VS 151

937

G70143

BALTIMORE CITY HEALTH DEPARTMENT 420.1 G70143

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): LEROY J. FRITZ

2. DATE OF DEATH: 1/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2211 North Calvert.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-4
D. STREET ADDRESS (If rural, give location): 2211 North Calvert Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	Jan 9th 1904	44	11	23

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Hand
10B. KIND OF BUSINESS OR INDUSTRY: Husbandry
11. BIRTHPLACE (State or foreign country): Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas Fritz
14. MOTHER'S MAIDEN NAME: Betsy E. Sheens
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Anna Reynolds ADDRESS: 2211 N. Calvert St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: John R. Davis M.D.
23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/5/49	Moreland Park	Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William Cook Inc. ADDRESS: 1217 St. Paul St.

VS 151

94a

70144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

20011 G70144 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E. Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County N.Y. city
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 333 Central Park, West (If rural give location)
(e) Citizen of foreign country? ... (Yes or No) If yes, name country —

3 (a) FULL NAME Mabel Holmes Ribon Mrs. CHARLES B. THOMPSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife CHAS. B. THOMPSON
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-22-1875

8. AGE: Years	Months	Days	If less than one day
73	2	12	... hr. ... min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harvey Tilden
13. Birthplace Ohio

MOTHER
14. Maiden Name Ella Nelson
15. Birthplace Ohio

16 (a) Informant (Completed) Mabel R. Thompson 211 King George st. Annapolis Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/49 (month) (day) (year)
(c) Cemetery or crematory Rock Creek
Location Washington D.C.
18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St. Balto. Md.
19 (a) JAN 4 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1949, at 2 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1948 to Jan. 3 1949, and that I last saw her alive on Jan. 3 1949.

Immediate cause of death
Duetto Hypostatic congestion
Due to multiple subluxations
Due to ...
Other Conditions ...
(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
of autopsy: ...

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Richard R. Beach M.D.
Address Union Memorial Hosp. Date signed 1/3/49

VS 150

Beach 55E

G70145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.0 Registered No. G70145

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LOUIS POLTRACK

2. DATE OF DEATH: 1/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): 3402 Woodale Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W	Married		62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Shimmen
14. MOTHER'S MAIDEN NAME: Rose
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Bessie Poltrack ADDRESS: 3402 Woodale Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) A. S. C. V. D.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Emil L. Kayser M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-4-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc. ADDRESS: 2100 Eutaw Place

VS 151

939

670146 434.1 ✓ 670146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dr. ALBERT LA BORWIT.

2. DATE OF DEATH: 1-2-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3602 Dennlyn Road

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15 11

c. Length of stay in Baltimore: 35 Yrs. ~~Mos. Days~~

D. STREET ADDRESS (If rural, give location): 3602 Dennlyn Road

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married		49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chiropractor

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob La Borwit

14. MOTHER'S MAIDEN NAME: Merel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Anna La Borwit ADDRESS: 3602 Dennlyn Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Congestive heart — 8 Months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 27 19 48 *to* Jan 2 19 49, *that I last saw the deceased alive on* Jan 2, 19 49, *and that death occurred at* 12:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: M J Baylin M. D.

23B. ADDRESS: 7040 Eutaw St

23C. DATE SIGNED: 1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-4-49

24C. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship

24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1949

REGISTRAR'S SIGNATURE: Lucy Williams M.D.

25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Place

VS 150

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G70147 ✓ 420.0 G70147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ISAAC LERNER
2. DATE OF DEATH: 1-3-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3806 Chatham Road
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
c. Length of stay in Baltimore: 35 Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 3806 Chatham Road 15 10
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 1/3/79
9. AGE (In years last birthday): 70 If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Israel
14. MOTHER'S MAIDEN NAME: Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Julius Feldman ADDRESS: 3806 Chatham Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 15 Minutes

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis + arterio-sclerotic heart disease — 15 years

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1947 *to* Jan 3, 1949 *that I last saw the deceased alive on* Dec 5, 1948, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jack Cohen M.D. M. D.
23B. ADDRESS: 1804 Eutaw Place-17
23C. DATE SIGNED: 1/3/1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-4-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Place

VS 150

937

670148 443 670148

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): John W. Stanley

2. DATE OF DEATH: January 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1815 Presstman St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: resident before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1815 Presstman Street 15-2

c. Length of stay in Baltimore — Yrs.: Life; Mos.; Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	3/17/1869	79 78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore City

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Washington Stanley

14. MOTHER'S MAIDEN NAME: Louise Eves

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Elinor Stanley 1815 Presstman St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Type Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 16, 1948, *to* Jan. 2, 1949, *that I last saw the deceased alive on* Jan. 2, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm A Bikle M. D.

23B. ADDRESS: 601 N. Calhoun St.

23C. DATE SIGNED: 1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/5/49

24C. NAME OF CEMETERY OR CREMATORY: Arlington Mem Park

24D. LOCATION (City, town, or county) (State): Balto Co.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Frank L Brunston — ADDRESS: 101 N Montgomery St

VS 150

937

70149 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 70149

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 Division St
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Penn. Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Lomack

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Nannie Lomack

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 52 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James H. Lomack
13. Birthplace Va

MOTHER
14. Maiden Name Addie Hill
15. Birthplace Va

16 (a) Informant James Lomack
(b) Address 1607 N. Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-49 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George W. Kelson
(b) Address 1303 Presstman St

19 JAN 4 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27- 1948, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1948 to 12-27 1948, and that I last saw him alive on 12-27 1948.

Immediate cause of death Cerebral hemorrhage

Due to Hypertension

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Bagby M.D.
Address Provident Hosp Date signed 12-27-48

VS 150

70150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

002 G70150 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Carson Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Warren, Mary Elizabeth

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1939

8. AGE: Years	Months	Days	If less than one day
14	11	1	hr. min.

9. Birthplace Burdette, Va.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

PARENTS

12. Name Wm Warren
13. Birthplace Va

MOTHER

14. Maiden Name Mary Harris
15. Birthplace Va

16 (a) Informant Mary Warren
(b) Address 1118 Carlton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/49 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Fred. H. Kelson
(b) Address 1303 Pressman St

19 (a) JAN 4 1949 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1949, at 7.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1948, to 1/1 1949, and that I last saw her alive on 1/1 1949.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to —

Due to —

Other Conditions Tuberculosis Peritonitis
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr Marcus N. Moore Sr M.D.
Address Provident Hospital Date signed 1/3/49

VS 150

13B

670:51

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. 670:51

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY LOUISE HAWKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	

6 (b) Name of husband or wife Arthur Hawkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/1/1896

8. AGE: Years	Months	Days	If less than one day
52	5	30	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation janitor

11. Industry or business

FATHER
12. Name James Cox
13. Birthplace Md

MOTHER
14. Maiden Name Susie Stewart
15. Birthplace

16 (a) Informant Anthony Hawkins
(b) Address 1614 Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/49 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pressman St

19 (a) JAN 4 1949 (Date rec'd by registrar) (b) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1948, at 11 58 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 22 1948 to 12 31 1948 and that I last saw her alive on 12 31 1948.

Immediate cause of death	Duration
Pulmonal Asthenia	
Laryngeal Ca of the	
Due to Pulmonary complications causing	
Due to Compression of the Trachea	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Hahn

Address University Hosp Date signed 1-2-49 M. D.

VS 153

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

670::2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

434.1 Registered No.

670::2

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DAVID SAMUEL McKENZIE

2. DATE OF DEATH January 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1100 Mount Street 16-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	widowed	Sept. 27, 1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Jamaica, British West Indies	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mary Sterrett	1631 Laurens Street

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute congestive heart failure	
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
Carl L. Pryer M.D.		January 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Jan. 6, 1949	Mount Auburn	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 1949	Huntington Williams, M.D.	Geo. S. Kelson	1303 Pennsylvania Ave

VS 151

93E

70:53

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

Registered No. 53

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 West 28th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 West 28th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH YARBOROUGH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1878

8. AGE: Years	Months	Days	If less than one day
70	5	21	hr. min.

9. Birthplace Raleigh, N. C.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Robert Perry
13. Birthplace N. C.

MOTHER
14. Maiden Name Mollie Williams
15. Birthplace N. C.

16 (a) Informant Mrs. Minnie Johnson
(b) Address 531 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-49 (month) (day) (year)

(c) Cemetery or crematory
Location Raleigh, N. C.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 JAN 4 1949 (Date rec'd by registrar) (b) Huntington for Williams Mortuary

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Dec. 31, 1948, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31/48 to 19 . and that I last saw h[illegible] alive on 12/31 1948.

Immediate cause of death [illegible]

Due to [illegible]

Due to [illegible]

Other Conditions [illegible]
(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D. Barksdale M. D.
Address 536 N. Carey St. Date signed 1/8/49

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 153

M. D. Barksdale + 1/8/49

70154 ✓ 442 70154

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): William H. Parron
2. DATE OF DEATH: Jan. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1338 Argyle Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1338 Argyle Ave. 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored	Married	July 15, 1871	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	U. S.

13. FATHER'S NAME: Jesse Parron
14. MOTHER'S MAIDEN NAME: Charlotte ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		M's Helen Parron- 1338 Argyle Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) UREMIA	5 days.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Hypertensive C-V Renal Disease	6 mos.
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/10, 1948, *to* 1/3, 1949, *that I last saw the deceased alive on* 12/31, 1948, *and that death occurred at* 9 A. m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Preston Grant M. D.	601 N. Carrollton	1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 6, 1949	Western Star Cem.	Catonsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JAN 4 1949	Huntington Williams, M.D.	M's Frances A. Hemsley 578 W. Biddle St.

VS 150

1312

G70135 ✓ 443 G70135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Mary Rebecca Wright

2. DATE OF DEATH January 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2507 Morgan Street

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2507 Morgan St. 25-22

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	Aug. 9, 1881	67	4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Baltimore, Md.	U. S.

13. FATHER'S NAME Moses Lewis

14 MOTHER'S MAIDEN NAME Lucy ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
		Mr. Perry Wright-	2507 Morgan St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

DUE TO

(B) Hypertensive C-V Disease — 16 yrs (History)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5/4 , 1948 *to* 1/2 , 1949, *that I last saw the deceased alive on* 12/30 , 1948, *and that death occurred at* 10 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
J. Paxton Grant M. D.	601 N. Carrollton	1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Jan. 5, 1949	Mt. Auburn Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 1949	Huntington Williams, M.D.	Mrs. Frances A. Hemsley	578 W. Biddle St

VS 150

92)

4-70156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4201 Registered No. 4-70156

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SILAS A. ROTH

2. DATE OF DEATH: January 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4200 Penhurst Avenue
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4200 Penhurst Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	June 18, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): wool merchant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington County, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Abraham Roth
14. MOTHER'S MAIDEN NAME: Amanda Grosh
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: J. Claudine Roth ADDRESS: 4200 Penhurst Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary thrombosis	
	Myocardial infarction	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Recent automobile accident	

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH:
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): public place
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Monroe And Saratoga Streets
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Jan. 2, 1949 m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Argument after sideswiping another car

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]
23C. DATE SIGNED: 1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 6, 1949	Druid Ridge	Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Harry N. Armacost 4204 Ridgewood Ave.

VS 151

94a

Certificate Corrected 1-10-49

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

382 Registered No. 2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 S. Wolfe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 S. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vincent Wielechowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widow

6 (b) Name of husband or wife Maryanna Wielechowski
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1881 (1879)

8. AGE: Years	Months	Days	If less than one day
67 (69)	7	2	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Julius Wielechowski
13. Birthplace Poland

MOTHER
14. Maiden Name Ambrozewicz
15. Birthplace Poland

16 (a) Informant Genevieve Kidd.
(b) Address 5623 Orville Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1949 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Balto. County

18 (a) Funeral director John M. Wilbur
(b) Address 40 S. Chester Street

19 JAN 4 - 1949 (Date rec'd by registrar) (Huntington Williams M.D. Registrar)

MEDICAL CERTIFICATION

1045

20. DATE OF DEATH Jan 2 1949, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1948 to Jan. 2 1949, and that I last saw him alive on Jan. 1 1949.

Immediate cause of death Thrombosis Cerebral Artery — Duration 3 days
Due to Diabetes Mellitus — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny M.D.
Address 2200 E Madison St Date signed 1/3/49 M. D.

VS 150

61

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 180 6270:48

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 170 days
(e) Length of stay in Baltimore (yrs., mos., or days): 170 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mass. (b) County:
(c) City or town: Watertown
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 74 Arsenal St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: RONALD JAMES PURCELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 25, 1924

8. AGE: Years	Months	Days	If less than one day
24	5	8	hr. min.

9. Birthplace: Mass. (Town, county, and state)
10. Usual Occupation: AB Seaman
11. Industry or business:

FATHER
12. Name: Harry Purcell
13. Birthplace: Nova Scotia

MOTHER
14. Maiden Name: Jessie Brown
15. Birthplace: England

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-49 (month) (day) (year)
(c) Cemetery or crematory: St - Peters
Location: Furnace & Bunker Sts

18 (a) Funeral director: Fred B Wolverton
(b) Address: 403 E 25th St

19 (a) JAN 4 - 1949 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2 19 49 at 9:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1948, to Jan. 2 1949, and that I last saw him alive on Jan. 2 19 49.

Immediate cause of death	Duration
Carcinoma of right kidney with generalized metastasis	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: 7/29/48
Major findings of operation: Carcinoma of right kidney with metastasis
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Dr. van Ackeren, Medical Director
Address: Medical Officer in Charge Date signed: 1/3/49

VS 150

520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Please see that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0159

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 683 Vine St.
(c) Hospital or institution: 4-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 683 Vine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Mackey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1866

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Eastern Shore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Joseph Mackey
13. Birthplace Md.?

MOTHER 14. Maiden Name Mary ?
15. Birthplace Md.

16 (a) Informant Mattie Mackey,
(b) Address 683 - Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-49 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Halstead

18 (a) Funeral director A. Halstead
(b) Address 918 - Mund Hill Ave.

19 (a) JAN 4 - 1949 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1948, at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1948, to 12/31 1948
and that I last saw h e alive on 12/29 1948.

Immediate cause of death Uremia — Duration 10 days
Due to Hypertensive C-V Renal Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Preston Grant
Address 601 N. Carrollton Date signed 12/31/48 M.D.

VS 150

X

G70150 BALTIMORE CITY HEALTH DEPARTMENT 420.1 G70150

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Aaron Fink

2. DATE OF DEATH January 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3722 ParkHeights Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 44 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3722 Park Hgts, Ave. 15-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	July 15, 1882	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant	Store Fixture	Russia	

13. FATHER'S NAME Morris Hyman Fink

14. MOTHER'S MAIDEN NAME Hannah Freda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	No		Tillie Fink	3722 ParkHeights Ave

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	3 mo.
DUE TO	Arteriosclerosis	5 yrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
(C)	Coronary Artery Disease	4 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 19 46 *to* Jan 3, 19 49 *that I last saw the deceased alive on* Jan 3 1949 *and that death occurred at* 2.50 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr M D. Sterling M. D.	2426 Eutaw Pl	1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 4, 1949	Shaarei Zion Cemetery	Hamilton Ave Rosedale

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 1949	Thurlington Williams, M.D.	Sol Levinson & Bros	1126 W North Ave

VS 150

94a

To be approved by Medical Examiner

G70161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420 Registered No. G70161

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Israel Heilpern

2. DATE OF DEATH: 1/3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Sinai Hosp (D.O.A.)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp. (D.O.A.)

C. Length of stay in Baltimore: 45 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4233 Park Heights Avenue 15 3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	Wh	Widowed	1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cabinet Maker		Russia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Aaron Heilpern	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	no		Mrs Shirley Flinkman	4233 Park Heigh Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — DUE TO

(B) Congestive Failure — DUE TO

(C) Coronary Hd. Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

Earl L Kruger

For: Dr. Wm. G. Hamilton

CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____ 19__ *to* (D.O.A.) 1/3/49 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 8:00 a m. *from the causes stated, on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marjorie Oxman M. D.	Sinai Hosp.	1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-4-49	Bnai Israel Cong	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 '49	Huntington Williams, M.D.	Sol Levinson & Bros	1124 W North Av

VS 150

94a

G70:1:2 BALTIMORE CITY HEALTH DEPARTMENT 550 D G70:1:2

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Miss KATHERINE DAUSES
2. DATE OF DEATH 1/3/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSP
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) DUNDALK
c. Length of stay in Baltimore Yrs. 4 Mos. FEE Days
D. STREET ADDRESS (If rural, give location) 8259 BULLNECK ROAD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W		SEPT 27, 1893	55 56	3	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE		MARYLAND	

13. FATHER'S NAME JOHN A. DAUSES
14. MOTHER'S MAIDEN NAME K. DUERBECK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) LUPUS ERYTHEMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO AC DESQUAMATION

(B) AC NEPHRITIS
DUE TO BRONCHO PNEUMONIA

(C) AC APPENDICITIS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/11, 1948, *to* 1/3, 1949, *that I last saw the deceased alive on* 1/3, 1949, *and that death occurred at* 12:25 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. W. Hunter M. D.	CHURCH HOME	1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-9-49	Holy Redeemer	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 4 - 1949	Huntington Williams, M.D.	Leonard J. Luck - Harford Rd 5305

VS 150

121

70103 CERTIFICATE

BALTIMORE CITY HEALTH DEPARTMENT 332 Registered No. G70103

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Hildebert H. Reymann

2. DATE OF DEATH Jan 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1749 Linwood St. 9-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Sept 1 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman

10B. KIND OF BUSINESS OR INDUSTRY Revere Copper & Brass

11. BIRTHPLACE (State or foreign country) Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Arthur Reymann

14. MOTHER'S MAIDEN NAME Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Wife ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1949 *to* Jan 3, 1949, *that I last saw the deceased alive on* Jan 3, 1949, *and that death occurred at* 10:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE John M Buchness M. D.

23B. ADDRESS Mercy Hospital

23C. DATE SIGNED 1-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1-6-49

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town, or county) Balto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 4 - 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR L. J. Luck ADDRESS 5305 Harford Rd.

VS 150

83B

170164

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

155 ✓ Registered No. 170164

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rachel Virginia Lindsay

2. DATE OF DEATH Mon. Jan. 3 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 15 S. Conkling St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore About 20 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-8
D. STREET ADDRESS (If rural, give location) 15 S. Conkling St. ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Feb. 27 1906	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Montgomery Co. Md.	—

13. FATHER'S NAME Columbus Ricketts

14. MOTHER'S MAIDEN NAME Gertrude S. Sneiders

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	214-16-9721	Charles T. Lindsay	15 S Conkling St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Terminal Bronchial Pneumonia	1 yr
DUE TO (B)	Carcinoma of Bile Ducts	
DUE TO (C)	Metastasis.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1948 19__, to Jan 3rd 49, 19__, *that I last saw the deceased alive on* Jan 3 19 49, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Vangh M.D. M. D.	692 Park Blvd	1-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Wednesday 5, 49	Rockville Union Cem	Rockville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 - 1949	Huntington Williams, M.D.	R Howard Evans	1400 S. Charles St.

VS 150

46F

G70165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered G70165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 N. Chapple St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 N. Chapple St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Griffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Carrie Griffin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 24 1879

8. AGE: Years	Months	Days	If less than one day
69	-	7	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Unkown
13. Birthplace Unkown

MOTHER
14. Maiden Name Annie Griffin
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Myrtle Boykins
(b) Address 415 N. Bethel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3. 1949 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1949 2000 Brantly Ave.

19 (a) JAN 4 - 1949 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1948 to Dec 31 1948 and that I last saw h[illegible] alive on Dec 31 1948

Immediate cause of death Organic Heart Disease — Duration Instant

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Garland Schmidt M. D.
Address 1534 Druid Hill Ave Date signed Jan. 3, 49

VS 150

670166

ES-

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82

Registered No. 670166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVENUE
(c) Hospital or institution: BALTO. CITY HOSPITALS 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 ARCHER STREET.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife Lottie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1892

8. AGE Years	Months	Days	If less than one day
56	1	21	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Richard Young
13. Birthplace Md.

MOTHER
14. Maiden Name Susie Smith
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVENUE

17 (a) Buial (Burial, cremation, or removal) (b) Date thereof Jan. 5. 1949 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.
JAN 4 - 1949 (Date rec'd by registrar) Hunter for Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1948, at 4:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8- 1932 to 12-31 1948, and that I last saw h im alive on 12-31 1948.

Immediate cause of death: BRONCHOPNEUMONIA — Duration: 3 DAYS
CEREBRAL THROMBOSIS — 1 WEEK
Due to
Due to
Other Conditions SYRINGOMYELIA — 16 YEARS
NEPHROSCLEROSIS
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: NONE
of autopsy: BRONCHOPNEUMONIA, NEPHROSCLEROSIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Georgia M. D.
Address BALTIMORE (Int Hosp. Date signed 1-1-49

VS 150

83B

670167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. 670167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 N. Dallas St.
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days) life

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 N. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hines E. Or Mary Bertie Hines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6. 1889

8. AGE: Years 59 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hines
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Unkown
15. Birthplace Unkown

16 (a) Informant Annie Jenkins
(b) Address 101 N. Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 4 1949 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 (a) JAN 4 - 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29- 1948, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1- 1948 to 12-29 1948
and that I last saw her alive on 12-29- 1948.

Immediate cause of death: Carcinoma of Liver — Duration: Last Sick
Due to: Cardio-Renal disease
Due to: Hepatitis
Due to: Exposure
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas R. Blake M. D.
Address 1603-N Carolina Signed

X 1/3/48.

VS 150

70168

MEDICAL EXAMINERS CASE
BALTIMORE CITY HEALTH DEPARTMENT ✓ E903.0-N821.0

CERTIFICATE OF DEATH

Registered No. 70168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N. Loudon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Bell ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of husband or wife Edward F. Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 22 1859

8. AGE: Years	Months	Days	If less than one day
89	0	10	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Joseph J. Tambrill
13. Birthplace

MOTHER
14. Maiden Name Mary Jane Young
15. Birthplace

16 (a) Informant Mrs. William C. Ingham
(b) Address 412 N. Loudon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-1949 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave

19 (a) JAN 4 - 1949 (Date rec'd by registrar) (b) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Jan 1949 at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Sept 1948 to 1 Jan 1949. and that I last saw h er alive on 1 Jan 1949.

Immediate cause of death
Terminal Pneumonia
Due to
CERTIFICATION APPROVED BY
Due to
For: C.J. Lubinski, M.D.
CHIEF OR ASST. MEDICAL EXAMINER.
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation 1 Dec 48
Major findings of operation: Fract left femur - appl of cast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 24/7
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1-26-48 at 2 A M
(c) Where did injury occur? 412 N. Loudon Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Tripped over rug & fell to floor
23. Signature Ernest G. Amarando M. D.
Address Maryland Gen'l Hosp. Date signed 1 Jan 49

VS 150

186a

G70169

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1 ✓ G70169 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES W. T. JULIER
2. DATE OF DEATH: 1/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 56 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3045 Belmont Avenue 16-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	May 25. 1892	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LINOTYPE Operator	A.S. ABEL Co	Baltimore, Md.	

13. FATHER'S NAME: Charles H. Julier
14. MOTHER'S MAIDEN NAME: Frances Rieve

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	213-03-3702	Mrs. Norval Julier	3045 Belmont Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Inspection of Inquiry

22. *I certify that I took charge of the remains described above, held an* Inspection of Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: John R. Davis M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-6-1949	Lorraine Park	Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 - 1949	Huntington Williams, M.D.	D. Howard Strong	3207 W. North Ave

VS 151

94a

No Reg. approved by coroner

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT E 903.0 M 721.0 6701.0

Registered No.

CERTIFICATE OF DEATH

Certificate Collected 1-10-49

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert

(c) Hospital or institution:

Union Memorial Hosp - 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 47

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2742 N. Charles

(If rural give location)

(e) Citizen of foreign country? O (Yes or No)

If yes, name country O

3 (a) FULL NAME Mrs. Annie E. Clark (Annie E. Clark)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	W

6 (b) Name of husband or wife deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29, 1854

8. AGE: Years	Months	Days	If less than one day
94	11	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

MOTHER / FATHER

12. Name Richard R. Rutt (D)

13. Birthplace England

MOTHER

14. Maiden Name Margaret Catlin

15 Birthplace Maryland

16 (a) Informant Mrs. James E. Patterson

(b) Address 2742 N. Charles

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.5.49 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem. Pikesville, Md.

Location

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JAN 4 - 1949 (Date rec'd by registrar) (b) Contraction Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3-49 19 , at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1948 to 1-3 1949.

and that I last saw her alive on 1-3 1949

Immediate cause of death (a) cachexia Duration

with Ca

Due to (b) senility

Due to (c) fr. femur, left

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation: No

of autopsy: No

CERTIFICATION APPROVED BY Thos. A. Merrill CHIEF MEDICAL EXAMINER M.D.

PHYSICIAN

-Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/6

(a) Accident, suicide, or homicide? Accident

(b) Date of occurrence 11 18 1948 at ? M

(c) Where did injury occur? 2742 N. Charles (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home While at home

(e) Means of injury Slipped and fell on linoleum floor from chair

23. Signature [illegible] M.D.

Address Union Mem. Hosp. Date signed 1-5-49

VS 150

186a

G701.1

BALTIMORE CITY HEALTH DEPARTMENT 334 ✓ G701.1 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N. Hilton St.
(c) Hospital or institution: Sherwin's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HELEN LEE KAIN

3 (b) If veteran, name war: -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife: Edgar Depew Kain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1871

8. AGE: Years	Months	Days	If less than one day
77	11	4 5	hr. min.

9. Birthplace Dorchester Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William A. Twilley
13. Birthplace Md.

MOTHER
14. Maiden Name Sophie E. Higgins
15. Birthplace Md.

16 (a) Informant Mrs. Helen E. Birkitt
(b) Address 4315 Wentworth Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/49 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 4 - 1949 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1949, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1946 to 1/1 1949 and that I last saw h alive on 1/1 1949.

Immediate cause of death: Cerebral Embolism — Duration
Due to:
Due to: Cerebral arterio sclerosis
Other Conditions: Arterio Sclerosis and Hypertension
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Holmuck M.D.
Address 4710 Liberty Ht. Date signed 1/3/49

VS 150

838

67012

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4201L

Registered No. 67012

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANK (SAUGNEY) SHAUGHNEY

2. DATE OF DEATH: January 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 922 Madison Avenue 11-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Oct. 2, 1903	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Meat Cutter	Provision	Pa.	

13. FATHER'S NAME: Frank J. Shaughney

14. MOTHER'S MAIDEN NAME: Mary Walsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Genevieve Shaughney (Wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary artery disease	
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil H Hoyer M.D.		1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1/4/49	Holy Sepulchre	Phila, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 4 1949	Huntington Williams, M.D.	M. Cook Inc 1247 St Paul St

VS 151

94a

G70173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70173 Registered No. 24747

107

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 N. Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 4
(e) Length of stay in Baltimore (yrs., mos., or days) 30 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 N. Chester St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Isiah Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
~	216 10 4783	M.	C	M.

6 (b) Name of husband or wife Mamie Brown
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Jan. 2. 1903

8. AGE: Years	Months	Days	If less than one day
45	11	28	hr. min.

9. Birthplace Rock Hill S.C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Nathaniel Brown
13. Birthplace S.C.

MOTHER
14. Maiden Name Sallie ?
15. Birthplace S.C.

16 (a) Informant Mamie Brown
(b) Address 1004 N. Chester St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 2 / 48 (month) (day) (year)
(c) Cemetery or crematory
Location Rock Hill S. Carolina

18 (a) Funeral director Mrs. Robt G. Elliott & Son
(b) Address 1129 N. Carolina St

19 (a) JAN 4 - 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1948, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1948, to 12-30 1948, and that I last saw him alive on 12-30 1948.

Immediate cause of death Bronchial Pneumonia — Duration 6 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Lightsey M. D.
Address 501 Cherry Hill Rd Date signed 12-30-48

VS 150

MEDICAL EXAMINERS CASE

G70174 ✓ E900.7-N855.0 G70174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

CM. 105742

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 S Clinton ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Louis Smith ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10 -1866

8. AGE: Years	Months	Days	If less than one day
82	-	23	hr. min.

9. Birthplace Balto. MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

CERTIFICATION APPROVED BY
For: Wm. G. Helfrich, M.D.
CHIEF OR ASST. MEDICAL EXAMINER

FATHER
12. Name George Smith
13. Birthplace VA.

MOTHER
14. Maiden Name Anna Louise ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/49 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director John D Connelly
(b) Address 1949 Eastern Ave Baltimore, Md.

19 (a) JAN 4 1949 (Date rec'd by registrar) (b) Furniture for Williamsburg, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 2 - 49, at 5.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-1946, to 1-2-1949.
and that I last saw h im alive on 1-2-1949.

Immediate cause of death ? CVA

Due to Gen atherosclerosis

Due to

Other Conditions Bronchopneumonia
Fracture of Hip, Lft
(Include pregnancy within 3 months of death)

Date of operation 12/31/48
Major findings of operation: Fractured Hip
of autopsy: Bronchopneumonia

Duration	
mins.	
yrs.	
days	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/12
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12/30/48 at 9 00 P M
(c) Where did injury occur? Balt. Balt md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? BCH While at work? no.
(Specify type of place)
(e) Means of injury fell down steps

23. Signature Gordon Craft M. D.
Address Balt City Hosp Date signed 1/3/49

VS 150

To Be Approved By The Chief Medical Examiner. 186a

G70175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No. G70175

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN NICHOLS

2. DATE OF DEATH: January 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Prince Georges
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Laurel
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Nov. 26, 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Laurel, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Nichols

14. MOTHER'S MAIDEN NAME: Ida Shorts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.

17. INFORMANT: Julia Nichols (wife), ADDRESS: Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bronchopneumonia

(C) Multiple fractures of long bones

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Washington Blvd. near Laurel, Md.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: December 31, 1948 7:30 P.M.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21F. HOW DID INJURY OCCUR? Pedestrian Struck by auto.

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Rogers M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 1-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/6/49	Prey Hill	Laurel, Pr. Geo. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Ridgley Selby ADDRESS: 401 Washington Blvd Laurel, Md

170c

VS 151

67016

BALTIMORE CITY HEALTH DEPARTMENT ✓ 190 Registered No. 67016

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: Univ. Hosp. 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2932 E Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wallace Glenn

3 (b) If veteran, name war	3 (c) Social Security Account No. 213-09-0809

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Violette Glenn
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Oct 30 1908

8. AGE: Years	Months	Days	If less than one day
40	2	3	hr. min.

9. Birthplace Elvio (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Sparrows Point

FATHER
12. Name Walter
13. Birthplace Elvio

MOTHER
14. Maiden Name Ida Lingdale
15. Birthplace N Y

16 (a) Informant Violette Glenn
(b) Address 2932 Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) JAN 4 - 1949 (Date rec'd by registrar) (b) Lunsford Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1948, at 4:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1948 to 1-2 1948, and that I last saw h[illegible] alive on 1-2 1948.

Immediate cause of death	Duration
Cerebral Metastasis	
Due to Malignant Melanoma of Skin	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Smith Jr. M. D.
Address Univ. Hosp. Date signed 1-2-49

VS 150

53

G701.77 ✓ 4260 G701.77

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Keidel

2. DATE OF DEATH: 1/2/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 622 N. Glover St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 622 N. Glover St

c. Length of stay in Baltimore — Yrs. Mos. Days: 7-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	Aug 17 1869	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	—		

13. FATHER'S NAME: John C. Eder

14. MOTHER'S MAIDEN NAME: Rose Cann ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—		Joseph T White	35 N Patapsco St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C.V disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
D C Gubernicki M.D.		1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 8 1949	Baltimore Elm	E Wabash Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 1949	Huntington Williams M.D.	John C Morsan	3000 E Baltimore St

VS 151

93D

G70178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70178

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Marie G. Jablonsky

2. DATE OF DEATH: Jan 2 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 428 N Robinson St 6-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Femal	White	Married	Dec 1885	63.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Penna

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Adam Gernet

14. MOTHER'S MAIDEN NAME: Anna Baner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT — ADDRESS: Bernard Jablonsky 428 N Robinson St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CIRRHOSIS OF LIVER — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) SECONDARY ANEMIA — 6 mos

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO		

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* NOV 6, 19 48, *to* JAN 2, 19 49, *that I last saw the deceased alive on* JAN 2, 19 49 *and that death occurred at* 2.15 Pm., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James F. Cavanaugh M.D. M. D.	3014 W. Eden St	1-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 4 1949.	Schoop Cemetery	Hassisling Pa

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 - 1949

REGISTRAR'S SIGNATURE: Evelyn Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: John C. Moran 3000 E Baltimore St

VS 150

124B

70179 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E970.2 N977.0 Registered No. 70179

1. NAME OF DECEASED (Type or Print): FRANCES NOETH

2. DATE OF DEATH: January 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 700 Fleet Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 868 Park Avenue 11-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	March 2, 1894	54	10	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Saukup
14. MOTHER'S MAIDEN NAME: Frances Desadek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: Albert J. Saukup ADDRESS: 4114 Moravia Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Barbiturate Poisoning
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 868 Park Avenue
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: 12-8-48 (?) ? m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Probably ingestion of numinal tablets

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☒, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl L. Rogers M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-4-49	Holy Redeemer	Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Schimunek Funeral Home Inc ADDRESS: 2601 E. Madison, St.

VS 151

1633

G70180 ✓ 170 G70180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Edith CARTER. | 2. DATE OF DEATH 1/3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY —

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home + Hospital.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore.

c. Length of stay in Baltimore 30 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 604 E 41st St. 1-1

5. SEX	6. COLOR OR RACE	7. MARRIED, [redacted] (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEM.	White.		Aug 28 1898	50	3 / 5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife			

13. FATHER'S NAME Mr. Charles Holland.

14. MOTHER'S MAIDEN NAME Mrs Elsie Cooksey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No —		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis from Ca of st Breast.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
10/28/47	Ca of Breast.	YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No.	No	No

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
No m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	None

22. *I hereby certify that I attended the deceased from* 12/27, 1948, to 1/3, 1949, *that I last saw the deceased alive on* 1/3, 1949, *and that death occurred at* 10:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. W. Winter M. D.	Church Home & Hosp.	1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 5-1949	London Park	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 - 1949	Huntington Williams, M.D.	Putnam & Hoe	2324 N Charles St

VS 150

50

G70181 443 ✓ G70181

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) GENEVA GREER HEBARAD

2. DATE OF DEATH January 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore five years (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 1337 Argyle Avenue 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Married	12-16-1915	33				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	———	Albany, Ga.	U.S.A.

13. FATHER'S NAME Willie Barnes

14. MOTHER'S MAIDEN NAME Mattie Riley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
———	———	———

17. INFORMANT Mattie Bell Butler, ADDRESS 868 N. 8th St. Phila., Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive C. V. Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
———	———	YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	———	———

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
——— m.		———

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Royer M.D.		1/4/48

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, county) (State)
Burial	1/9/49	Darby Cem	Philadelphia, Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 - 1949	Huntington Williams, M.D.	William A Jackson	916 Penna Ave 927

VS 151

G70182 420.1 G70182

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): John H. Cromwell

2. DATE OF DEATH: Jan. 3,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3124 Keswick Road
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3124 Keswick Road 13-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Jan 16, 1890	58	11	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman, Street Cleaning
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12 CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Cromwell
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: John Cromwell Jr. ADDRESS: 3124 Keswick Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
(B) Coronary Heart Disease — 1 year ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 24, 1948 *to* Jan 3, 1949 *that I last saw the deceased alive on* Jan 3, 1949 *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Wallenstein M. D.
23B. ADDRESS: 878 W 36th St
23C. DATE SIGNED: 1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 5,1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Grant H Leary ADDRESS: 814 W 36th St.

VS 150

94a

G70183

BALTIMORE CITY HEALTH DEPARTMENT 420-1

CERTIFICATE OF DEATH

Registered No. G70183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14
(c) Hospital or institution Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 833 W. North Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Strasburger (Leo Strasburger)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1892

8. Age: Years	Months	Days	If less than one day: hr.	min.
56	5	4	27	

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Prop. Artificials

11. Industry or business Flower Shop

FATHER
12. Name Aaron Strasburger,
13. Birthplace Germany

MOTHER
14. Maiden Name Fannie Eberenthal
15. Birthplace Balto. Md.

16 (a) Informant Miss. Bertie Strasburger
(b) Address 833 W. North Ave

17 (a) Burial (b) Date thereof 1/5/49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levenstein & Sons
(b) Address 1702 Eutaw Place

19 (a) JAN 4 - 1949 (b) Thurlington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 19 49 at 7:45 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 12/13 19 48 to 1/2 19 49
and that I last saw her alive on 1/1 19 49

Immediate cause of death Cardiac failure — Duration

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature Charles J. Blank M.D.
Address Maryland Gen. Hosp. Date signed

VS 150

94a

G70184

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G70184

1. NAME OF DECEASED (Type or Print): William Colvin

2. DATE OF DEATH: December 30, 1948

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 317 N. Calvert Street 4-1

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1302 W. Lexington Street Fayette Nursing Home

C. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Single	? 11/19/1874	74	1	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Ireland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
?	?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		D.P.W.	records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

(B) Hypertensive Cardio Vascular disease — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 29, 1948 *to* Dec 30, 1948, *that I last saw the deceased alive on* Dec 30, 1948, *and that death occurred at* 1140 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Glassman M. D.	253 W. Fayette St	Jan 3, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1/5/49	New Cathedral Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 - 1949	Huntington Williams, M.D.	Wm. Cook, Inc.,	1217 St. Paul Street

VS 150

X

70185

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

585 Registered No. 70185

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Virginia Brandt

2. DATE OF DEATH: January 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2641 Wilkins Avenue

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2641 Wilkins Avenue 20-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	Widowed	Sept. 6, 1875	73	3	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Maryland	

13. FATHER'S NAME: Charles LeBon

14. MOTHER'S MAIDEN NAME: Katherine Kahler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Frank M. Fambook, 2641 Wilkins Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute Cardiac Dilitation	One day
DUE TO (B)	Arterio Sclerosis	?
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Cholecystitis	1 year
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	?	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 20, 1948 *to* Jan 3, 1949 *that I last saw the deceased alive on* Jan 3, 1949 *and that death occurred at* 9.50 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Glassman M. D.	753 W. Fayette St	Jan 3, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1/6/49	Loudon Park Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 4 1949	Huntington Williams, M.D.	Wm. Cook, Inc., 1217 St. Paul Street

VS 150

127a

670186

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 ✓ Registered No. 670186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2322 E. Hoffman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 4
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2322 E. Hoffman St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Whilhelmina Wolters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John M.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15th 1861

8. AGE: Years	Months	Days	If less than one day
87	1	17	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Krome
13. Birthplace Germany.

MOTHER
14. Maiden Name —
15. Birthplace Germany.

16 (a) Informant Mrs. Otilia Meyer
(b) Address 2322 E. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5th 1949 (month) (day) (year)
(c) Cemetery or crematory Balto
Location E. North Ave Ext

18 (a) Funeral director Leo G. Brook
(b) Address 1701-03 N. Patterson Park ave

19 JAN 4 - 1949 (Date rec'd by registrar) (Huntington Williams Mortuary)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2nd 1949, at 6 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 25 Dec 1948, to 2 Jan 1949, and that I last saw her alive on 2 Jan 1949.

Immediate cause of death Cerebral hemorrhage — Duration 7 day
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1513 N. Milton Ave Date signed 4 Jan 49

VS 150

83a

70187

J1 - 59508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

491 ✓ 70187 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 3-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 854 Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Helen Pajkowska

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Damazie (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29. 1879

8. AGE: Years	Months	Days	If less than one day
69 70	4	4	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joe Weselak
13. Birthplace Poland

MOTHER
14. Maiden Name Catherine Rutkowski
15. Birthplace Poland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Jan 5/49 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastfield Ave.

19 (a) JAN 4 1949 (Date rec'd by registrar) (b) Curtis Bay Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1949, at 4pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1940, to Jan. 2 1949, and that I last saw h er alive on Jan. 2 1949.

Immediate cause of death	Duration
Bronchopneumonia	12 hrs
Due to	
Due to	
Other Conditions Hypertension Heart Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kuntz Jr. M.D.
Address Balt City Hosp Date signed Jan 4 49

VS 130

937

G70:46 7811 ✓626 G70:88

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Effie Arthur
2. DATE OF DEATH: Jan. 2 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 114 N. Broadway 2-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	5-21-04	44				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Greece	

13. FATHER'S NAME: Bill Anthis
14. MOTHER'S MAIDEN NAME: Catherine Cymerinos

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records	JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Pulmonary embolism ?	5 min.
DUE TO (B)	Post-operative pelvic abscess and intestinal obstruction	approx. 1 month
DUE TO (C)	Chronic ulcerative colitis	10 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12/17/48	Pelvic abscess	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct. 14, 1948 *to* Jan 2, 1949 *that I last saw the deceased alive on* Jan 2, 1949, *and that death occurred at* 3:28 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard F. Kruspe M. D.	JOHNS HOPKINS HOSPITAL	1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JAN. 5. 1949	GREEK ORTHODOX EVANGELISMOS	BALTIMORE, MARYLAND

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 1949	Huntington Williams, M.D.	Geo. J. Agnew Funeral Home Inc.	1112 N. Mt. Royal Ave. 1394

VS 150

670189 BALTIMORE CITY HEALTH DEPARTMENT 231 670189

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Raymond J. Leach

2. DATE OF DEATH: 1/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14
D. STREET ADDRESS (If rural, give location): 223 N. Luzerne Ave. 6-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W		2/13/1894	54	10 / 20	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: John W Kennedy Co
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Leach
14. MOTHER'S MAIDEN NAME: Johanna Heaphy
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO. 216-05-4089
17. INFORMANT: Wife ADDRESS: Lean A. Leach

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7hrs.
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertension — unknown
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): None.
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/3, 1949, *to* 1/3, 1949, *that I last saw the deceased alive on* 1/3, 1949, *and that death occurred at* 7:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: John Robert Stell M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: JAN 6 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Old Frederick Rd MD.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Diffel Bros. ADDRESS: 1800 E Lombard St.

VS 150

832

670150 PONTON 141 670150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Allie Lee Ponton

2. DATE OF DEATH: Jan 2 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1740 E. Balto. St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address of location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1740 E. Balto. St 6-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Married	Jan 23 - 1906	42	11	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Steel Mill	Crow Cork Seal Co	Martinsburg West Va.	U.S.

13. FATHER'S NAME: James David Ponton

14. MOTHER'S MAIDEN NAME: Emma F. Oden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO. 234-01-7279

17. INFORMANT: Viola M. Ponton — ADDRESS: 1740 E. Balto. St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of tongue — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 1948 *to* Jan 2, 1949 *that I last saw the deceased alive on* Jan 2, 1949 *and that death occurred at* 1:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Melvin L. Solomon M. D.	129 S. Broadway	1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 5 49	Oak Lawn Cem.	Eastern Ave Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 - 1949	Huntington Williams, M.D.	Dippel Bro.	1800 E Lombard St

VS 150

4513

G70191

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70191

1. NAME OF DECEASED (Type or Print): GEORGE TREMBORG

2. DATE OF DEATH: 1/3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1836 N. Chester St. 8-5

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Apr. 5th 1873
9. AGE (In years last birthday): 75 — If Under 1 Year: Months 8, Days 29 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Carrie Bodine Connor ADDRESS: 1836 N. Chester St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: ? weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Disease — ? years

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 3, 1949, *to* Jan. 3, 1949 *that I last saw the deceased alive on* Jan. 3, 1949, *and that death occurred at* 6.35 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Alfred H. Dann M. D.
23B. ADDRESS: Maryland General Hospital
23C. DATE SIGNED: 1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount
24D. LOCATION (City, town or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. J. Timanus Son
ADDRESS: 1931 E. Lafayette Ave.

931

VS 150

C70:192

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 107

C70:192

1. NAME OF DECEASED (Type or Print): CORA JOHNSON ADAMS

2. DATE OF DEATH: Dec. 31, 1948

3. PLACE OF DEATH:
A. Baltimore City, Maryland 129 Winter St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): -
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto. City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 129 Winter St 231

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Married	11/10/1893	55	1	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Domestic	Balto. Md	U.S.A.

13. FATHER'S NAME: Henry Johnson

14. MOTHER'S MAIDEN NAME: Cora Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	None	Lloyd Adams	129 Winter St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Influenza, (acute) — 12/22/48 to 12/31/48

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/22/ 1948 *to* 12/31/ 1948, *that I last saw the deceased alive on* 12/31/ 1948, *and that death occurred at* 12:00 m., *from the causes and on the date stated above.*

23A. SIGNATURE	M. D.	23B. ADDRESS	23C. DATE SIGNED
M. D. Taylor		1522 Harlem Ave.	1/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/4/49	Mt. Auburn	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 4 - 1949	Huntington Williams, M.D.	Chas Horton	512 Cornelian Ave

VS 150

G70193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

444 ✓

Registered No. G70193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5002 Frederick Rd
(c) Hospital or institution:
The Gundry Sanitorium - attnd 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9½ yrs
(e) Length of stay in Baltimore (yrs., mos., or days) many years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5002 Frederick Road
(If rural give location)
(e) If foreign born, how long in U. S. A.? ← years

3 (a) FULL NAME Lena Bamberger (Lena Bamberger)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Widow

6 (b) Name of husband or wife ? Bamberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-22-1870

8. AGE: Years	Months	Days	If less than one day
78	11	14	hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation Saleswoman - Retired

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Morris Rosenbaum, daughter
(b) Address The Dwight, Cumberland, Md

17 (a) Removal (b) Date thereof 1/5/49.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory ?
Location Cumberland, Md.

18 (a) Funeral director Harris Funeral Home
(b) Address 902 Eutaw Place

19 (a) JAN 5 1949 (b) Huntington Williams, M.E.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1949, at 12:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1938, to Jan. 5 1949, and that I last saw him alive on Jan. 5 1949.

	Duration
Immediate cause of death: Nasal hemorrhage - 2	1 day
Due to hypertension & ulcerated nasal septum	years
Due to	
Other Conditions Diabetes mellitus mild	years

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Reuben K. Gundry M. D.
Address 5002 Frederick Rd, Balto 19 Date signed 1-5-49

VS 3

61

570194 ✓ 442

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 570194

1. NAME OF DECEASED (Type or Print): Nannie Pearce

2. DATE OF DEATH: Jan. 3 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 535 E. 27th St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 535 E. 27th St. 9-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	M	Feb. 15 1873	75	11	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward R. Poole

14. MOTHER'S MAIDEN NAME: Susan J. Eager

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Margaret Poole — ADDRESS: 535 E. 27th St.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Degeneration — INTERVAL BETWEEN ONSET AND DEATH: 3 Months
DUE TO
(B) Arteria-Renal Disease — 10 yrs or more
DUE TO
(C) Hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23A. SIGNATURE: Wheeler P. Donell M. D.

23B. ADDRESS: 730 Eutaw Pl

23C. DATE SIGNED: 1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 6, 1949	Loudon Park	

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: W. W. Cook — ADDRESS: 1217 St. Paul St.

VS 150

131a

G70195

Dr. Albert Eisenberg
2026 North Avenue

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-42 G70195
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Emma Peters

2. DATE OF DEATH: Jan. 2. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 723 N. Collington Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 723 N. Collington Street 7-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Widowed	Dec. 6. 1870	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Aloysius Wetzelberger
14. MOTHER'S MAIDEN NAME: Elizabeth Kuhber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. Fred. Peters, ADDRESS: 723 N. Collington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 20 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension via Cardiovascular Renal Disease — 3 years

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 29, 1948, *to* January 2, 1949, *that I last saw the deceased alive on* January 1, 1949, *and that death occurred at* 4:40A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert Eisenberg M. D.	2005 E. North Ave	January 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-5-49	Holy Redeemer	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Ruck, ADDRESS: 5305 Harford Rd.

VS 150

1312

Dr. Sawyer

BALTIMORE CITY HEALTH DEPARTMENT 33 G70196

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Charles H. Eger

2. DATE OF DEATH: Jan. 3. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 6116 Moyer Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6116 Moyer Avenue

c. Length of stay in Baltimore: Yrs. 27 Mos. 5 Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Sept. 14, 1882	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		E asthampton Mass.	

13. FATHER'S NAME: Herman Eger

14. MOTHER'S MAIDEN NAME: Marie Hillert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mr. Karl Eger, Malvern Ave. Towson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	1 day
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Generalized arteriosclerosis	5 yrs.
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	—	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 10, 1948, to Jan 3, 1949 *that I last saw the deceased alive on* Jan 3, 1949, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George Sawyer M.D. M. D.	4808 Harford Rd.	1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-5-49	Moreland Park	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 5 1949	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

83a

G70197 260 G70197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 749 Dolphin Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 749 Dolphin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

17 3

3 (a) FULL NAME Ernest W. Bannister

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
Male	Colored	married	Ella Bannister	years

7. Birth date of deceased (mo., day, yr.) December 25 1869

8. AGE: Years	Months	Days	If less than one day hr.	min.
71	0	7		1917

9. Birthplace Baltimore Maryland (town, county and state)
10. Usual Occupation Cook
11. Industry or business

MOTHER / FATHER
12. Name Unknown
13. Birthplace Unknown
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Ella Bannister
(b) Address 749 Dolphin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1949 (month) (day) (year)
(c) Cemetery or crematory Western Star Cemetery
Location Baltimore County Md

18 (a) Funeral director Joseph A Sterling
(b) Address 661 West Lane Street

19 (a) JAN 5 1949 (Date rec'd by registrar) (b) Huntington Ave Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 11 1949 at 1055 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1948 to 1-1 1949 and that I last saw h[illegible] alive on 1-1 1949

Immediate cause of death Diabetic Mellitus
Due to Bronchopneumonia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
2 d
3 hr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 661 Harlem Date signed 1-6-49

VS 150

61

1598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

422.2

Registered No. G703678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 N. Carey St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 N. Carey St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Herbert

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife John Herbert
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) June 5. 1848

8. AGE: Years	Months	Days	If less than one day
60	6	21	hr. min.

9. Birthplace St. Mary Co. Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Unknown

FATHER
12. Name Wm. Shorter
13. Birthplace St. Marys Co Md

MOTHER
14. Maiden Name Catherine Smith
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Rosie Johnson
(b) Address 920 Woodyear St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7-49 (month) (day) (year)
(c) Cemetery or crematory St Peters Cemetery
Location Baltimore Md
18 (a) Funeral director Wm Brooks.
(b) Address 1463 N. Carey St
19 JAN 5 1949 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4- 1949. at 9:30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 12-1- 1946. to 1-4- 1949 and that I last saw h[illegible] alive on 1-3- 1949.

Immediate cause of death Myocarditis — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St. Date signed 1-5-49

VS 150

93E

670:99

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

610, Registered No. 670:99

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN WRINEY FRIDAY

2. DATE OF DEATH: January 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: 10 Yrs. - Mos. - Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2813 Simpson Street 9-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Married	Feb. 29, 1888	60	10	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cement Finisher	Laborer	Charlotte, N.C.	U.S.A.

13. FATHER'S NAME: John Friday

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		719-10-235	Mrs. Allean Friday	2813 Simpson St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes

DUE TO

(B) Hypertrophied Prostate

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12-3-48	Hypertrophied Prostate - Autosection	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-23, 1948 *to* 1-2, 1949 *that I last saw the deceased alive on* 1-2, 1949, *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	808 W Fremont Ave	1-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 7, 1949	Mt. Auburn	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 5 1949	Huntington Williams, M.D.	Mrs. George H. Holland 1631 Druid Hill Ave.

VS 150

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70208 4371 420,0 G70200

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): George Johnson

2. DATE OF DEATH: JAN 2 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. 40 years Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 1644 W. North Ave. 15-4

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 3-31-00
9. AGE (In years last birthday): 48 yrs. If under 1 year: Months Days; If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer Stationary
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Fred Johnson
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anterior Myocardial Infarct — Interval between onset and death: 2 wks
DUE TO
(B) Arteriosclerotic Heart Disease — 1 yr
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION: 0
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-19- 1948 *to* 1-2- 1949 *that I last saw the deceased alive on* 1-2- 1949 *and that death occurred at* 3.30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Richard S Ross M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 5, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Mrs. George H. Holland 1631 Druid Hill Ave.

VS 150

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70-01

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

200.2 670.01

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Jethro Kelly

2. DATE OF DEATH: January 3 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 18 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 3030 Ascension St. 25-22

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Colored	married	7-1-08	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): S.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Pearson Kelly

14. MOTHER'S MAIDEN NAME: Mandy Hardy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Monocytoma (Reticulum cell Sarcoma)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-20-48 *to* 1-3 1949 *that I last saw the deceased alive on* 1-3 1949, *and that death occurred at* 11 45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sherman M. Mellinkoff M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 6, 1949

24C. NAME OF CEMETERY OR CREMATORY: Spartanburg Family Lot S.C.

24D. LOCATION (City, town, or county) (State): Spartonsburg, S.C.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: ADDRESS: Mrs. George H. Holland 1631 Druid Hill Ave.

VS 150

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670.02 ✓ 5811 670.02

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): JAMES W. MASEMORE

2. DATE OF DEATH: 1/4/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: 23 yrs ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 833 W. North Ave. 14-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		Aug. 16 - 1890	58	4 / 19	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lineman
10B. KIND OF BUSINESS OR INDUSTRY: C. & P. Telephone Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jeremiah Masemore
14. MOTHER'S MAIDEN NAME: Mary E. Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 212-03-6767
17. INFORMANT: W. E. Masemore ADDRESS: 3131 Clifton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Portal Cirrhosis	? years
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Chronic Alcoholism	? years
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Bronchopneumonia, right lung Delirium tremens	3 weeks ? months

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/11, 1948 *to* 1/4, 1949, *that I last saw the deceased alive on* 1/3, 1949, *and that death occurred at* 3:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Alfred H. Dann, M. D.
23B. ADDRESS: Maryland General Hospital
23C. DATE SIGNED: 1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 6 - 49
24C. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
24D. LOCATION (City, town, or county) (State): Elkton, Cecil Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John L. Miller ADDRESS:

VS 150

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70.03 420.1 C70.03

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ARTHUR L. COLE

2. DATE OF DEATH Jan. 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1500 Lockwood Rd. 27-9

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	White		April 27, 1893	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Accountant	—	Baltimore	USA

13. FATHER'S NAME Philip Cole

14. MOTHER'S MAIDEN NAME Ada Rutledge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS (Name)
—	—	Wife	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

(B) Coronary thrombosis

DUE TO

(C) Generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from Dec. 24, 1948, to Jan 3, 1949, that I last saw the deceased alive on Jan 3, 1949, and that death occurred at 12½ p m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William F. Cox 3rd M. D.	Union Memorial Hospital	1-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	1/5/49	Greenmount	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 5 1949	Huntington Williams, M.D.	H. O. Meares and Son	805 N. Calvert St.

VS 150

94a

G70.04 ✓ 120.1 G70.04

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mary Ann C'Conor

2. DATE OF DEATH: Jan. 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2840 St. Paul St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ---

c. Length of stay in Baltimore: 81 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
2840 St. Paul St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 2840 St. Paul St. 12-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	-----	81	-- / --	-- / --

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-----	-------	Baltimore, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Galvin	Mary Leland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
No		Herbert A. O'Conor 16 Charlcote Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hours.

DUE TO

(B) Arteriosclerosis — C

DUE TO

(C) Chronic Myocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senility

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1948, *to* Jan 3, 1949, *that I last saw the deceased alive on* Jan 3, 1949, *and that death occurred at* 8½ P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles R. Goodbrough M. D.	2923 St Paul St	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/6/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JAN 5 1949	Huntington Williams, M.D.	H. C. O'Meara and Son 805 N. Calvert St.

VS 150

93D

0-05

BALTIMORE CITY HEALTH DEPARTMENT 600.0 670.05

CERTIFICATE OF DEATH

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1604 E. Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 E Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Thrower

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Ellen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1871

8. AGE: Years	Months	Days	If less than one day
77	4	13	hr. min.

9. Birthplace Brunswick Co. Va.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

MOTHER / FATHER
12. Name Unknown
13. Birthplace
14. Maiden Name Henrietta Price
15. Birthplace Va

16 (a) Informant Ellen Thrower
(b) Address 1604 E Biddle St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5/49 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County
18 (a) Funeral director Mrs. Ruth J. Elliott & Dgt.
(b) Address 1129 N. Caroline St
19 JAN 5 1949 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1949 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1948 to 1-1 1949, and that I last saw h alive on Dec. 31 1948.

Immediate cause of death Uremia — Duration 1 week
Due to pyelonephritis — 1 year
Due to prostatitis — 2 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. W. McDaniel M. D.
Address 807 N. Caroline Date signed 1-4-49

VS 180

139a

G70.06 ✓ E9027-N455D G70.06

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert Faller Guy
2. DATE OF DEATH: Jan. 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Union Memorial H.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.
C. Length of stay in Baltimore: — (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: (Edgewood Nursing Home)
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6000 Bellona Ave. 27-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	White		Jan 31, 1865	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Maryland	USA

13. FATHER'S NAME: Robert J. Guy
14. MOTHER'S MAIDEN NAME: Elizabeth Akers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—	—	Mrs Edith Davis	Baltimore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) ~~due to~~ Paralytic Ileus Coronary arteriosclerosis & partial occlusion	?
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) ~~due to~~ Arteriosclerosis, general CERTIFICATION APPROVED BY H.G. Merrill M.D. for: Wm. C. Helfrich M.D. CHIEF OR ASST. MEDICAL EXAMINER	?
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) Nephrosclerosis. Fracture, Rt Hip paralytic ileus	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12-31-48	Fracture Rt. Hip	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	Hospital	Union Memorial Hosp. 12/2

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Dec, 25, 1948 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Fell out of bed

22. I hereby certify that I attended the deceased from Dec. 25, 1948, to Jan 3, 1949, that I last saw the deceased alive on Jan. 3, 1949, and that death occurred at 8:17 p m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
F. Frank Snyder, M. D.	Union Memorial Hosp.	January 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan/6/49	Greenmount	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 5 1949	Huntington Williams, M.D.	Stewart & Mowen Company	108 W. North Ave. Balto. 11, Md.

VS 150

186a

670.07 H20.1 ✓ 670.07

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): DR. AUGUST HERMAN Pfund

2. DATE OF DEATH: Jan. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore, Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4404 Bedford Place 27-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	MARRIED	December 28, 1879	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired professor

10B. KIND OF BUSINESS OR INDUSTRY: Johns Hopkins Univ.

11. BIRTHPLACE (State or foreign country): Wisconsin (Madison)

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: August Henry Pfund

14. MOTHER'S MAIDEN NAME: Anna Schiebel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: UMH records — ADDRESS: Baltimore Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 7 hr.

DUE TO

(B) Hypertensive + Arteriosclerotic heart disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 4, 1949, *to* Jan 4, 1949, *that I last saw the deceased alive on* Jan 4, 1949 *and that death occurred at* 10:15 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: A. Pfund M. D.

23B. ADDRESS: Union Memorial Hosp

23C. DATE SIGNED: 1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/8/49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: WILLIAM J. TICKNER & SONS Balto., Md.

VS 150

937

CERTIFICATE CORRECTED 2-8-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420 ✓

Registered No. 170.08

170.08 BIRTH NO.

1. NAME OF DECEASED (Type or Print) Veanmary Ghee

2. DATE OF DEATH Jan. 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 709 Bradley St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 709 Bradley St. 17-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Married		43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor	Sparrow Point	Fornsville, Va.	U.S.A.

13. FATHER'S NAME: Squire Ghee

14. MOTHER'S MAIDEN NAME: Lillie Knight

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Josephine Ghee ADDRESS: 709 Bradley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy / Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L Ryan M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 5, 1949	Mt. Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Elroy O. Wilson

VS 151

94a

70.09

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

002

Registered No. 70.09

1. NAME OF DECEASED (Type or Print): JAMES R. TYDINGS

2. DATE OF DEATH: January 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: All Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 728 Pennsylvania Avenue 17-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
male	colored	Single	Nov. 19. 1910	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk		Baltimore	U.S.A.

13. FATHER'S NAME: Walter Tydings

14. MOTHER'S MAIDEN NAME: Sarah Platt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT / ADDRESS: Lavinia Hill 728 Penn. Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George L. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: January 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 7. 1949	Mt. Auburn Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR / ADDRESS: Elroy O. Wilson 1000 Brantly Ave

VS 151

12B

670-10

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B976.0 H876

Registered No. 670-10

BIRTH NO.

1. NAME OF DECEASED (Type or Print): PAUL ROSENTHAL

2. DATE OF DEATH: January 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5614 Stonington Avenue
C. Length of stay in Baltimore: 15 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5614 Stonington Avenue 28-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
male	white	married	April 12,1902	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Proprietor	Fire Proven Products	Memphis, Tenn.	

13. FATHER'S NAME: Isaac Rosenthal

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	219-20-8500	Mrs. Georgia E.Rosenthal, 5614 Stonington Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bullet Wound of Brain
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] ~~CAUSE OF~~ DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	5614 Stonington Avenue, Baltimore, Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Jan. 3, 1949 m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	firearms

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
Emil L. Rupp M.D.		Jan. 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Entombment	Jan. 7,1949	Lorraine Cemetery	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 5 1949	Huntington Williams, M.D.	Ellis Lamoreaux	4510 Liberty Heights Ave.

VS 151

164c

670-11 ✓ 334 670-11

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Marie Schmitt

2. DATE OF DEATH: January 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3611 Howard Park Avenue
c. Length of stay in Baltimore: 60 Yrs. ~~DAYS~~ ~~HRS~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3611 Howard Park Avenue 28-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	July 15, 1868	80 yrs	5	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Germany	

13. FATHER'S NAME: Andras Schmitt

14. MOTHER'S MAIDEN NAME: Katherine Melber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Mr. Frederick Centofanti, ADDRESS: 3611 Howard Park Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Sclerosis
DUE TO
(B) Generalized arteri sclerosis -
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/16, 1948 *to* 1/4, 1949 *that I last saw the deceased alive on* 1/4, 1949 *and that death occurred at* 1 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: C. Holeneck M. D. | 23B. ADDRESS: 4710 Liberty Heights Ave. | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 6, 1949	Woodlawn Cemetery	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 5 1949	Huntington Williams, M.D.	Wallace Funeral	4510 Liberty Hgts Ave

VS 150

877

G70-12 X O ✓ G70-12

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 780

BIRTH NO.

1. NAME OF DECEASED (Type or Print): NINA I. BAYLESS

2. DATE OF DEATH: 1-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
C. Length of stay in Baltimore: 6 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen
D. STREET ADDRESS (If rural, give location): 114 No. Philadelphia Boulevard

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W	Feb. 10, 1871	77 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland.	U.S.A.

13. FATHER'S NAME: Luther OSBORNE

14. MOTHER'S MAIDEN NAME: Sarah Wells

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Charles Andrews	2901 Harview Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia and Cerebral Hemorrhage

DUE TO

(B) Cause undetermined

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-31-19~~48~~ *to* 1-5-19~~49~~, *that I last saw the deceased alive on* 1-5-19~~49~~, *and that death occurred at* 3~~4~~ *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John R. Smith, Jr. M. D.		

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	Jan. 9-1949	BARCUS Babies	Aberdeen Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 5 1949	Huntington Williams, M.D.	Henry Fanning Sons	Aberdeen Md

VS 150

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70.13 CERTIFICATE CORRECTED 8-26-52 L

JL - 123656 BALTIMORE CITY HEALTH DEPARTMENT 4201 Registered No. 670.13

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Newkirk Ste. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kalandes or William Kalandros or William Galanda

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Athena.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ? ?

8. AGE: Years	Months	Days	If less than one day
72 ?	3-		hr. min.

9. Birthplace ? Turkey ? (Town, county and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? Emanuel Kalandros
13. Birthplace ? Turkey

MOTHER
14. Maiden Name ? Maria
15. Birthplace ? Turkey.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-49 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd.

18 (a) Funeral director Lambros Inc
(b) Address 438-40 E. North Ave.

19 (a) JAN 5 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1949, at 12.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 19 48 to Jan. 3 19 49. and that I last saw h im alive on Jan. 3 19 49

Immediate cause of death Acute cardiac failure — Duration Asap
Due to Coronary thrombosis — 2 mo
Due to Generalized arteriosclerosis
Other Conditions Benign prostatic hypertrophy
(Include pregnancy within 3 months of death)
Date of operation 10-22-48 12-20-48
Major findings of operation: Benign prostatic hypertrophy
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Angelo A Pitsikas M. D.
Address 4940 Eastern Ave Date signed 1-5-49

VS 150

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G70214 BALTIMORE CITY HEALTH DEPARTMENT H20.1 G70214

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JOHN RANSOM WHITE

2. DATE OF DEATH: Jan. 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1400 W. Lexington St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ages Womens & Mens Home

C. Length of stay in Baltimore: Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1019 Poplar Grove St., 16-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	April 17, 1854	94	8	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Steel worker		Baltimore, Md.	

13. FATHER'S NAME: Richard White

14. MOTHER'S MAIDEN NAME: Mary A. Evans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Miss Matilda Leaverton	1019 Poplar Grove

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary occlusion — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 1948 to January 1949 *that I last saw the deceased alive on* Jan 4th 1949, *and that death occurred at* 9.50 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Newland Edward Day M. D.	4-E-33rd St - (R	Jan 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Jan 6, 1949	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 5 1949	Huntington Williams, MD	Ullrich Funeral Home	2008 Orleans

VS 150

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PICKARSKI ✓ 4212

G70c15 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70c15 — Registered No.

1. NAME OF DECEASED (Type or Print): Aleksandra Piekarski

2. DATE OF DEATH: January 4/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2115 Bank St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write "R.F.D." and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 2115 Bank St 1-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Married	Unk.	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home Wife		Poland	

13. FATHER'S NAME: Joseph Zalenski

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
No.	None	Mary Kurgan 2115 Bank St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Apoplexy — INTERVAL BETWEEN ONSET AND DEATH: acute

DUE TO

(B) Cerebral Arteriosclerosis — ?

DUE TO

(C) Chronic Myocardial Insuff. — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 2, 1949 *to* Jan 4, 1949, *that I last saw the deceased alive on* Jan 3, 1949, *and that death occurred at* 3A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas. J. Douglas M. D.	200 E. Pratt St	1/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	Jan. 8/49	Holy Rosary	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 5 1949	Huntington Williams, M.D.	Fred W. Ozgzuski 1900 Eastern Ave

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

H803 2 Registered No.

1. NAME OF DECEASED (Type or Print): DOLORES HELEN SUCHNICKI

2. DATE OF DEATH: January 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1928 Eastern Avenue 2-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	S	July 25, 1941	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
———	———	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Adam Szuchnicki

14. MOTHER'S MAIDEN NAME: Genevieve Alexalza

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
———	———	———		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull.
due to Intracranial hemorrhage.
due to Contusion and laceration of brain.
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street—public	Eastern Avenue & Chapel Street 2/1

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
January 4, 1949 12:30 p. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George G. Merrill M.D.	☐ / ☒	1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 6/49	Holy Cross Cem	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 5 1949	Huntington Williams, M.D.	Fred W. Ogozaguta	1930 Eastern Av

VS 151

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G70217 420.0 G70217

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS N. RICKELL

2. DATE OF DEATH: Jan. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1307 West 41st street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1307 West 41st street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	Married	Dec. 6, 1871	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.A.

13. FATHER'S NAME: Adam Rickell

14. MOTHER'S MAIDEN NAME: Mary C. Sniber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Unknown		J. Francis Reese	Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic Heart Disease	several years
DUE TO	(B) Senilized arteriosclerosis	many yrs
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Probable G. I. malignancy	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Dec 18, 1948, *to* Jan. 5, 1949, *that I last saw the deceased alive on* Jan. 5, 1949, *and that death occurred at* 9:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William J. Penner M. D.	11 W. 29th St. Balto	Jan. 5 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/8/49	Kriders	Westminster, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 5 1949	Huntington Williams, M.D.	J. Francis Reese	Westminster, Md.

VS 150

46M

BIRTH NO. 125130 — 670-18

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 670-18

1. NAME OF DECEASED (Type or Print): Jesse James Corbin

2. DATE OF DEATH: Jan. 4-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave.
C. Length of stay in Baltimore: 4 Months (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (Princess Ann MD.)
D. STREET ADDRESS (If rural, give location): Henryton Sanitorium 26-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	Single	March -12-1921	27				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	

13. FATHER'S NAME: Jesse Corbin

14. MOTHER'S MAIDEN NAME: Levina Carroll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records Balto. City Hospitals	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypernephroma of Kidney = Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 6 Months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
12/30/48	Enlarged right Kidney - ? Hypernephroma	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 12-16 *, 19*48*, to* 1/4/49 *, 19 , that I last saw the deceased alive on* 1/4/49 *, 19*48*, and that death occurred at* 11:15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Norman Cole M.D. M. D.	4940 Eastern Avenue Balto. Md	1/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-9-49	John Wesley	Princess Anne, Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: William H. James Jr. ADDRESS: Princess Anne, Md. 52a

VS 150

670-19

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 670-19

1. NAME OF DECEASED (Type or Print): ALFRED F. LEE

2. DATE OF DEATH: Jan 4, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland — Bell. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Gen. Hosp

c. Length of stay in Baltimore: Yrs. ___ Mos. ___ Days ___

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 34 E Burke Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	April 24, 1899	49 yrs	8 / 10	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shop Foreman	Dolphin Radiator Co.	Maryland	

13. FATHER'S NAME: William K. Lee

14. MOTHER'S MAIDEN NAME: Elizabeth Tucker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	216-01-0589	Mrs. Alfred F. Lee	34 Burke Ave., Towson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	1½ hr.
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 4, 1949 *to* Jan 4, 1949 *that I last saw the deceased alive on* Jan 4, 1949 *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter C. Vernon M.D. VERNON M.D.	Maryland Gen. Hosp	Jan 11 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 7, 1949	Prospect Hill Cemetery	Towson, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 5 1949	Huntington Williams, M.D.	John Burns' Sons	Towson, Md.

VS 150

83a

G70220

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

722.0 ✓

G70220

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Florence Boardley

2. DATE OF DEATH: Jan. 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1115 Argyle Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1115 Argyle Ave. 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col.	Widow	Dec. 25, 1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Richmond Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Haynes	Nannie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Effie Murgin	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Atrophic Arthritis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 14, 1948, *to* Jan 3, 1949, *that I last saw the deceased alive on* Dec 28, 1948, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Douglas Sheppard M. D.	604 N. Fulton Ave	1/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 6, 1949	Mt Auburn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 5 1949	Huntington Williams, M.D.	Mrs Katie R Williams	322 N. Schroeder St

VS 150

59a

B.C. 49-000043

670-21 770-VV 670-21

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Kirkpatrick

2. DATE OF DEATH: January 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4120 Hague Ave. 25-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	White	Child	1-1-49		3	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Md.	

13. FATHER'S NAME: Joseph Kirkpatrick

14. MOTHER'S MAIDEN NAME: Goldie Fraser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Records ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Erythroblastosis	4 days
DUE TO (B)	Pulmonary hemorrhage	48 hrs.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-4 1949 *to* 1-4 1949 *that I last saw the deceased alive on* 1-4 1949 *and that death occurred at* 9 25 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Ryan M. D.	JOHNS HOPKINS HOSPITAL	1/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	
B.	1/6/49	Holy Cross.	Broad Ln. Md	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 5 1949	Huntington Williams, M.D.	John L. McEvoy	1302 Fort Ave.

VS 150

161c

CERTIFICATE CORRECTED on 7-12-50

G70[illegible] BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70[illegible] Registered No.

1. NAME OF DECEASED (Type or Print): Richard H. Kroh

2. DATE OF DEATH: January 2, 1949 7:20 P.M.

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1510 Eutaw Place 14-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W.	Married	5/25/1898	50	7	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Hotel	Penna.	Yes

13. FATHER'S NAME: Henry Kroh

14. MOTHER'S MAIDEN NAME: Anna Elizabeth Shindledecker (Kirkbrown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Yes	W. W. #1	

17. INFORMANT: Edith M. Kroh ADDRESS: 1510 Eutaw Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/2, 1949, to 1/2, 1949, *that I last saw the deceased alive on* 1/2, 1947, *and that death occurred at* 7:20 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bobby L. Jones, M. D.	Franklin Square Hosp.	1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/6/49	U. S. National	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Hamilton for Williams, M.D.	William Cook Inc.	1217 St. Paul St.

VS 150

93D

G70223 420.1 ✓ G70223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) EMMA V. MC. KELDIN

2. DATE OF DEATH JAN-4-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1143 Carroll St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1143 Carroll St
C. Length of stay in Baltimore 57 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1143 Carroll St. 21-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 1 day: Hours / Min.
Female	White	Widowed	Aug 13. 1891	57	4 / 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William N. Bell
14. MOTHER'S MAIDEN NAME Elmira Flaharty
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO
17. INFORMANT Emma V. Burke ADDRESS 1106 Sterrett St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Occlusion. Acute.	
DUE TO		5 & 7.
(B)	Hypertension Cardio vascular	
DUE TO		
(C)	Heart disease.	

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1 19 48, to Jan 4th, 19 49, *that I last saw the deceased alive on* Jan 4th, 19 49 *and that death occurred at* 8.30 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M.D. 23B. ADDRESS 642 N. Eut. St. 23C. DATE SIGNED 1-5-49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Jan. 7. 1949
24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet
24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 6 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR ADDRESS Wm. Wm. John W. Sanfel Jr. 5311 Edmondson Ave.

VS 150

93D

G70-224 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1 ✓ Registered No. G70-224

1. NAME OF DECEASED (Type or Print): FRANK MOSKWIK

2. DATE OF DEATH: January 4, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: 45 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 839 South Bond Street 2-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	August 15, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Poland	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	218-10-2865	Mrs. Carrie Wanat	839 S. Bond Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Carl H. Rogers			1 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-8-49	St. Stanislaus	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Huntington Williams, M.D.	George A. Weber	705 S. Bond st

VS 151

94a

70225 B.C. 48-28835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. C70225

GM. 125623

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) N.B.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 N. Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Blake (Mother Roebertha Blake)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-28-48

8. AGE: Years	Months	Days	If less than one day
			13 hrs 55 min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Reece Blake
13. Birthplace N.C.

MOTHER
14. Maiden Name Roebertha George
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (b) Date thereof 12-31-48 At 9.00 Am
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) JAN 8 1949 (b) Lucretia Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 - 1948, at 7.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28-1948 to 12-29-1948 and that I last saw him alive on 12-29-1948.

Immediate cause of death
Prematurity

Duration 13hrs 55 min

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William P. Kean M. D.
Address Baltimore City Hospitals Date signed 12-30-48

VS 150

G70226 B.C.-48-28795

BALTIMORE CITY HEALTH DEPARTMENT

G70226

LCH-125521

CERTIFICATE OF DEATH 157a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 S. High Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL MERRIKEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/48

8. AGE: Years	Months	Days	If less than one day
			hr. 44 min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Merriken
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Dowdy
15. Birthplace Kentucky

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Cremation (b) Date thereof 12/23/48 at 9
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hosp.
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) JAN 6 1949 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22/48 19 , at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22/48 19 , to 12/22/48 19 , and that I last saw her alive on 12/22/48 19 .

Immediate cause of death Intracranial Hemorrhage — Duration

Due to

Due to

Other Conditions Hydrocephalus, Spina bifida
(Include pregnancy within 3 months of death)

Date of operation 12-22-48 Breech Extraction

Major findings of operation:

of autopsy: Hydrocephalus, Spina bifida

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Fetter, M.D.
M. D.
Address Baltimore City Hospitals Date signed 12-23-48

VS 153

X

G70227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70227

LCH-125463 B.C. 48-28834 16/c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 548 Robert Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY BAILEY (mother-Maybelle)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/48

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Maybelle Bailey
15. Birthplace N.C.

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Cremation (b) Date thereof 12/23/48 at 9 am
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) JAN 6 1949 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22/48 19 , at 2:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18/48 19 to 12/22/48 19 , and that I last saw him alive on 12/22/48 19 .

Immediate cause of death pulmonary hemorrhage. — Duration

Due to acute

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: pulmonary hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert L. Easton M. D.
Address Baltimore City Hospitals Date signed 1-22

VS 150

G70228 B.C. 48-27521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G70228

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 57 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 57 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balt city
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33rd & Calvert
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	wh.	single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Union Memorial Hosp.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Clayton Sockney Sockney
13. Birthplace Denver, Colorado

MOTHER
14. Maiden Name Mrs Margaret Olivia Ricketts
15. Birthplace Maryland

16 (a) Informant Mrs. Ruth Ricketts
(b) Address 2534 E. Oliver St.

17 (a) [illegible], cremation, or removal (b) Date thereof 12-19-48 (month) (day) (year)
(c) Cemetery or crematory Union Memorial Hospital
Location

18 (a) Funeral director
(b) Address

19 (a) JAN 6 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1948, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1948 to Dec. 17 1948 and that I last saw h[illegible] alive on Dec. 17 1948.

Immediate cause of death	Duration
Prematurity - 5 months gestation	
Due to	
Due to	
Other Conditions atelectasis	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paula Hunt M.D.
Address Union Memorial Hosp. Date signed 12/19/48

VS 150

Hospital Disposal
B.C. 48-28059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G70229

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 27-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Springfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Gaither
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-26-48
8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Calvin Gaither
13. Birthplace New York
MOTHER 14. Maiden Name Thelma Corbett
15. Birthplace ?
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location
18 (a) Funeral director Hoff Garfinkle
(b) Address
19 (a) JAN 6 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1948, at 9 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1948 to 12/28 1948 and that I last saw her alive on 12/28 1948

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.D. Holstein M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 12/29/48

VS 159

X

G70230 H 20.1 G70230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna K Dietrich

2. DATE OF DEATH: Jan 4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 811 N Port St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
COUNTY 811 N Port St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location) 7-2

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	widow	Jan 23 1869	79	11	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Balto	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nicholas Schmidt	Margaret Benson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Leroy Dietrich	811 N Port St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Thrombosis	2 days
DUE TO		
(B)	Arteriosclerosis of Coronary Arteries	4 yrs.
DUE TO		
(C)	Generalized Arteriosclerosis	20 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 3, 1949 *to* Jan 4, 1949 *that I last saw the deceased alive on* Jan 3, 1949 *and that death occurred at* 11 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Kenneth Dreibelbis M. D.	2441 N Hilton St.	1/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 7/49	Oak Lawn	Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Huntington Williams, M.D.	Welsh Funeral Home	2008 Orleans

VS 150

94a

G70231

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

171

Registered No. G70231

1. NAME OF DECEASED (Type or Print): MARTIN, BEATRICE

2. DATE OF DEATH: JAN. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland SOUTH BALTO. GEN. HOSP.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH BALTO. GEN. HOSP.
c. Length of stay in Baltimore: 4 MONTHS IN HOSP. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: MD.
B COUNTY: BALTO.
2125 N. PULASKI ST.
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)
D. STREET ADDRESS (If rural, give location)
15-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	MARRIED	MAY 13, 1907	41	7 / 23	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE		DOVER DELAWARE	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOSEPH SCOTT	BELL, EMMA MARY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		HOSP. RECORDS.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF CERVIX
DUE TO É GENERALIZED METASTASIS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 8 MONTHS

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
NONE		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* SEPT 23, 1948 *to* JAN 6, 1949 *that I last saw the deceased alive on* JAN 6, 1949, *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William B. Cooper Jr. M. D.	South Balto Gen Hosp.	1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jany 8/49	Odd Fellows -	Camden, Delaware

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 8 1949	Huntington Williams, M.D.	Harry E. Darby	1900 Eutaw Pl.

VS 150

48a

G70232

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

184 Registered No. G70232

1. NAME OF DECEASED (Type or Print): LINTHICUM CHASE BUNNELL

2. DATE OF DEATH: Jan. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2722 Maryland Ave.

c. Length of stay in Baltimore – (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2722 Maryland Ave. 12-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	May 5, 1383	65 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Accounting		Baltimore, Md.	USA

13. FATHER'S NAME: Luas Bunnell

14. MOTHER'S MAIDEN NAME: Nettie Baldwin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Mrs. Elsie D. Bunnell	2722 Maryland Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral hemorrhage.	Immediate.
DUE TO		
ANTECEDENT CAUSES. (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	①Carcinoma of bladder, ②Emphysema.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10/18 19 47 *to* 1/4 19 49, *that I last saw the deceased alive on* 7/16 19 48, *and that death occurred at* 1:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George W. Armstrong Jr. M. D.	1114 St. Paul St.	1/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/6/49	Loudon Park Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

52B

G70233

BALTIMORE CITY HEALTH DEPARTMENT 443

CERTIFICATE OF DEATH

Registered No. G70233

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs Carrie E Coates

2. DATE OF DEATH Jan 5 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 510 W Fayette St 4-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed	8. 6. 76	72 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Keeper	-	Balto. Md	USA

13. FATHER'S NAME: James H. Coster

14. MOTHER'S MAIDEN NAME: Caroline Kraft

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no	Mrs. Edith C. Bailey	721 Denison St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypertensive Cardio-Vascular Disease	5 yrs.
DUE TO (B)	Congestive Heart Failure	4 mos.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1 - 3, 1949 *to* 1 - 5, 1949 *that I last saw the deceased alive on* 1 - 5, 1949 *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard C. Hayden M. D.	Bon Secours Hosp	1-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/7/49	Mt. Olivet Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Turington for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

Vs 150

93D

G70234

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 ✓ G70234
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Katharine Smith Laur
2. DATE OF DEATH: 1-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Women's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3723 Northonia Rd. 15-9

c. Length of stay in Baltimore: Yrs. 50 Mos. Days.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 4-18-91
9. AGE (In years last birthday): 57 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Norfolk, Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward L. Stubbs
14. MOTHER'S MAIDEN NAME: M.A. Smith (Mary A. Smith)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Charles A. Laur — ADDRESS: 3723 Northonia Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis
DUE TO with metastases to cervical spine, lungs, liver, & diaphram
(B)
DUE TO
(C) Carcinoma of Breast (Rt.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: 7-30-48
19B. MAJOR FINDINGS OF OPERATION: Prefrontal lobotomy, Rt.
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-26-48, 19__, *to* 1-5-49, 19__, *that I last saw the deceased alive on* 1-4-49, 19__, *and that death occurred at* 5:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry Chesley Deaver M. D.
23B. ADDRESS: Women's Hospital
23C. DATE SIGNED: 1-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/8/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: WILLIAM J. TICKNER & SONS Balto. Md.

VS 150

50

G70235

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 ✓ G70235 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)	HARRISON MAGILL BROWNING
2. DATE OF DEATH	January 4, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	1820 N. Fulton Ave.
D. STREET ADDRESS (If rural, give location)	1820 N. Fulton Avenue 15-2
c. Length of stay in Baltimore (Yrs. Mos. Days)	65 yrs.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Feb. 9, 1862	86 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Linotype Machinist	U.S. Gov'nm't Printing Office	Montgomery Co., Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Luther H. Browning	Sarah L. Brandenburg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		no	Mrs. Mary V. Browning	1820 N. Fulton

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	12 days
DUE TO (B)	Arteriosclerosis	10 yrs.
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 24, 1948 *to* Jan 3, 1949, *that I last saw the deceased alive on* Jan 3, 1949, *and that death occurred at* 2 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Anthony J. Davis M. D.	800 W 33rd St	1-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/7/49	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

830

G70236

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

456 ✓ G70236

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) MARY Olo Judy

2. DATE OF DEATH Jan 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1508 Braddish Ave 16-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	May 24, 1933	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student		Maryland, Balto.	USA

13. FATHER'S NAME Oscar Judy

14. MOTHER'S MAIDEN NAME Martha Mullen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	no	Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lupus erythematosus
DUE TO Disseminatus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1½ mos.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/1/48 19__, *to* 1/4/49, *that I last saw the deceased alive on* 1/4/49, *and that death occurred at* 9:50 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Robert Shull M. D.	Mercy Hospital	1/5/48

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/8/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

153

70237 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

180 G70237 Registered No.

1. NAME OF DECEASED (Type or Print): MR. WILLIAM SHORT
2. DATE OF DEATH: 1/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSP
c. Length of stay in Baltimore: 27 DAYS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MICH
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): DETROIT
D. STREET ADDRESS (If rural, give location): 129 CHARLOTTE ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single +	MAY 29, 1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICAL WORKER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Newfoundalnd
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: MR. NEWTON SHORT
14. MOTHER'S MAIDEN NAME: HARRIET TUPE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. Newton Short, 129 Charlotte St., Detroit ADDRESS Mich.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypernephroma Left DUE TO Extension into Inferior vena cava — (INTERVAL BETWEEN ONSET AND DEATH) ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) Metastasis to right kidney + right lung.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/7, 1948 *to* 1/3, 1949, *that I last saw the deceased alive on* 1/3, 1949 *and that death occurred at* 9:10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. J. Moran M. D.	CHURCH HOME	1/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	1/6/49	Loudon Park Crematory	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

52a

G70238

Medical Examiner's Case
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH E 960.0-N912.0

G70238

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John Elmer DeHaven
2. DATE OF DEATH Jan 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 704 West 36th St. 13-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	February 11, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME David De Haven
14. MOTHER'S MAIDEN NAME Frances Robertson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS Union Memorial Hosp. Records Baltimore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Coronary Artery — INTERVAL BETWEEN ONSET AND DEATH
DUE TO Disease & Myocardial Damage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

(C) Pulmonary Tuberculosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fractured humerus, right

CERTIFICATION APPROVED BY
Earl L. Ruge M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home - front steps
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 704 West 36th Street, Balt. Md.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 1, 1949 7 p m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Slipped on steps. 13/7

22. *I hereby certify that I attended the deceased from* Jan 3, 1949, *to* Jan 5, 1949, *that I last saw the deceased alive on* Jan 4, 1949, *and that death occurred at* 2:25 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Frank Snyder III M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED Jan 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/8/49
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge
24D. LOCATION (City, town, or county) (State) Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 6 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Paul E. Schemanske Jr.
ADDRESS 3617-19 Eastern Ave.

VS 150

186a

70239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70239 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): N. S. Pendleton Stitt

2. DATE OF DEATH: 4 Jan. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: 7 dys (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sudbrook Park Pikesville
D. STREET ADDRESS (If rural, give location): 604 Upland Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	June 6 1910	38	6 / 28	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Trainer	Horse	Md	

13. FATHER'S NAME: Herbert D Stitt

14. MOTHER'S MAIDEN NAME: Mary Leche Pendleton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Yes World War II

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Intracranial Injuries	7 days
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C) Multiple Fractured Ribs,	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Fractured Right Clavicle	7 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street	Clarendon Ave., Pikesville

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑	21F. HOW DID INJURY OCCUR?
Dec. 28, 48 12:17 PM		Car hit tree

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Wm. H. Kammer, M.D.		5 Jan. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 6/49	Druid Ridge	Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 6 1949	Huntington Williams, M.D.	Henry Hankins Sons 4985 York Rd

VS 151

170c

G70240 B.C. 49-00098 761.0 761.0 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No. G70240

1. NAME OF DECEASED (Type or Print) Infant of Ellen K Brown

2. DATE OF DEATH 1-6-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1317 Struble

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 1 da Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE (317 Struble) B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1317 Struble St 15-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	negro		Jan 4/49	1 da		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) 1317 Struble

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME J. T. Brown

14. MOTHER'S MAIDEN NAME Ellen Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS 1317 Struble J. T. Brown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intra Uterine Strangulation DUE TO But finally Resuscitated — INTERVAL BETWEEN ONSET AND DEATH 1½ da

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 4, 1949, to Jan 6, 1949, *that I last saw the deceased alive on* Jan 5, 1949, *and that death occurred at* 2:30A m., *from the causes and on the date stated above.*

23A. SIGNATURE Wm R Boykin M. D.

23B. ADDRESS 1133 Monroe

23C. DATE SIGNED 1-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Jan. 6 49

24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary

24D. LOCATION (City, town, or county) (State) A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 6 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Metropolitan Funeral Home Inc.

ADDRESS 927 Monroe St

VS 150

160C

70241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70241

BIRTH NO. B.C. 48-28788 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Tishler

2. DATE OF DEATH: Jan 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp
c. Length of stay in Baltimore: 9 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2210 Baker St 15-3

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	12-28-48		9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-	-	Balto Md	

13. FATHER'S NAME: Ellis Tishler

14. MOTHER'S MAIDEN NAME: Anna Exler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Ellis Tishler	2210 Baker St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure

DUE TO

(B) Prematurity

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 28 1948 *to* Jan 5 1949 *that I last saw the deceased alive on* Jan 5 1949 *and that death occurred at* 2:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Josephs M. D.	Sinai Hosp	Jan 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-6-49	Hebrew Mt Carmel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Place

VS 150

159

G70242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1

G70242 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WALTER EIGNER

2. DATE OF DEATH: January 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 17-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored			53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Elgner

14. MOTHER'S MAIDEN NAME: Healy P

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: Alvita Brown 422 Pine St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease.

~~or~~ due to Myocardial scarring.

(B) Bronchiectasis of lung.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 1-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 9-49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State): North Carolina

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Elwyn O. Wilson ADDRESS: 1000 Blanchard ave

VS 151

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G70243 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.0 ✓

G70243 Registered No.

1. NAME OF DECEASED (Type or Print): Elmer Lee Willinger

2. DATE OF DEATH: 1-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3678 Falls Road 12-8

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. 45yrs. Mos. Days

4. SEX: M
5. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: Nov. 20, 1903
9. AGE (In years last birthday): 45yrs. If under 1 Year: Months Days If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Radio Repairs
10B. KIND OF BUSINESS OR INDUSTRY: Self employed.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Willinger
14. MOTHER'S MAIDEN NAME: Margaret Greenwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: ---
17. INFORMANT: Mrs. Margaret Willinger ADDRESS: 3678 Falls Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic heart disease
DUE TO
(B) and hypertensive cardiovascular disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pott's disease of spine with Compensatory Emphysema

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-9 1949 *to* 1-5 1949 *that I last saw the deceased alive on* 1-5 1949 *and that death occurred at* 6:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John R. Smith, Jr. M. D.
23B. ADDRESS:
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: January 7, 1949
24C. NAME OF CEMETERY OR CREMATORY: Moreland Memorial Park
24D. LOCATION (City, town, or county) (State): Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

VS 150

16

G70244

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70244

1. NAME OF DECEASED (Type or Print): Mrs. Laura Emily Meyls

2. DATE OF DEATH: January 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1333 Weldon Avenue
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 60 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1333 Weldon Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Widow	July 26, 1876	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Maryland	U.S.

13. FATHER'S NAME: John T. Baker

14. MOTHER'S MAIDEN NAME: Catherine A. Seyers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		—	Mrs. Katherine I. Harris	1333 Weldon Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cardio - Vascular - Renal Disease	?
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)	Hypertension	?
DUE TO (C)	~~Hemiplegia~~	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Hemiplegia left. side.	5 yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11 Dec. 1948 *to* 3 Jan, 1949 *that I last saw the deceased alive on* 3 Jan, 1949, *and that death occurred at* 7:55 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Samuel Lehrfeld M. D.	714 E. Preston St	4 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	January 6, 1949	Druid Ridge	Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Tuntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

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G70245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H20.0

G70246

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rose Adair Smith

2. DATE OF DEATH: January 5 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gold Spring Nursing Home

c. Length of stay in Baltimore: 30 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE / B. COUNTY: Baltimore Md 3305 Guilford Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 3305 Guilford Ave

12-2

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED? (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	November 16 1856	92		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	*****	Virginia	**

13. FATHER'S NAME: George C Adair

14. MOTHER'S MAIDEN NAME: Harriet Nottingham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	**	none	Mrs Lottie Rashleigh	3305 Guilford Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	ARTERIOSCLEROTIC HEART DISEASE	1yr
DUE TO (B)	Generalized Arteriosclerosis	10 yrs
DUE TO (C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* APRIL 15, 1946, *to* Jan - 5, 1949, *that I last saw the deceased alive on* 1/3, 1949, *and that death occurred at* 1 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Norman R Kleiman M. D.	3803 Edmondson Ave	1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	January 8 1949	Belle Haven Cemetery	Belle Haven Virginia

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR / ADDRESS: J Melville Jenkins 2713 Kirk Ave

VS 150

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70246 BALTIMORE CITY HEALTH DEPARTMENT 007 ✓ G70246

CERTIFICATE OF DEATH

BIRTH NO. Boutley Registered No.

1. NAME OF DECEASED (Type or Print) Mary Boutley or Botley

2. DATE OF DEATH 1-2-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 222 Ottobein St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

D. STREET ADDRESS (If rural, give location) 222 Ottobein Sheet 21-1

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	Col	married		58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Balto Md	

13. FATHER'S NAME William Black

14. MOTHER'S MAIDEN NAME Mary Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	—	none	James Boutley	222 Ottobein St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: ~~1 year~~ ~~1947~~ 6 mo

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-18, 1947, *to* 1-2, 1949 *that I last saw the deceased alive on* 12-23, 1948, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John P. Ulrich, Jr M. D.	1227 Washington Blvd	1-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/6/49	Mt Auburn	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Huntington Williams, M.D.	Isaiah L. Brown Son	1014 Monument St

VS 150

13B

AB-125732
G70247

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X N ✓ G70247
Registered No.

1. NAME OF DECEASED (Type or Print): Elmer Wagner

2. DATE OF DEATH: Jan. 3- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 5 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural- Middle River-Baltimore County
D. STREET ADDRESS (If rural, give location): Rural- Bourque Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	July 31-1909	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER.		Virginia	

13. FATHER'S NAME: Wallace B. Wagner. (D)

14. MOTHER'S MAIDEN NAME: Alice Demastus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No.		

17. INFORMANT: Records-Baltimore City Hospitals — ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) far advanced pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: ? 1yr.?
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Malnutrition, dehydration

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Jan 2, 1949 *to* Jan 3, 1949 *that I last saw the deceased alive on* Jan 3, 1949 *and that death occurred at* 11 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. Gray Tilletson, M. D.	Balt. City Hosp.	4 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Jan. 6-1949.	Churchville Cemetery	Churchville - Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Huntington Williams, M.D.	Charles J. Schwab	3512 Fred'k. Ave.

VS 150

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G70248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668.0 ✓

Registered No. G70248

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLOTTE RATCLIFFE MURRAY

2. DATE OF DEATH: 1/5/49

3. PLACE OF DEATH
A. Baltimore City, Maryland –
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME
c. Length of stay in Baltimore: About 12 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: CHURCH HOME
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 5
D. STREET ADDRESS (If rural, give location): BROADWAY & FAIRMONT

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	SINGLE	JUNE 21, 1871	77 78	6	14

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): WASHINGTON D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James D. Murray
14. MOTHER'S MAIDEN NAME: Elizabeth Spencer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Bailey Chapman
ADDRESS: Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ac Hemorrhagic Cystitis
DUE TO Ureteritis, Pyelitis & ?
(B) Uremia
DUE TO
(C) Gen Arteriosclerosis
Cachexia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/1, 1948, *to* 1/5, 1949, *that I last saw the deceased alive on* 1/5, 1949, *and that death occurred at* 8:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Donald A. Winter M. D.
23B. ADDRESS: Church Home & Hosp
23C. DATE SIGNED: 1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 6 1949
24C. NAME OF CEMETERY OR CREMATORY: St. Anne's
24D. LOCATION (City, town, or county) (State): Annapolis, Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1949
REGISTRAR'S SIGNATURE: Contingent for Williams, M.D.
25. FUNERAL DIRECTOR: John N. Taylor & Son
ADDRESS: Annapolis, Md

VS 150

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G70249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

422.1

G70249 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 W. LANVALE Street
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 N. Gilmor Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hughes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	M

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1900

8. AGE: Years	Months	Days	If less than one day
48	6	1	hr. min.

9. Birthplace Stuart County, Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Rachel Howard
15. Birthplace Stuart County, Maryland

16 (a) Informant Edna Johnson
(b) Address 1809 W. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/49 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St

19 (a) JAN 6 1949 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5, 1949, at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1948, to 1-5-1949, and that I last saw her alive on 1-4- 1949.

Immediate cause of death
Cardiac Failure — Duration Several days

Due to Cardio Vascular Disease — Duration Months

Due to Pleurisy — Duration Several wks

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 W. Franklin St. Date signed 1-6-49

VS 150

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BIRTH NO. G70250

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

2865 G70250 Registered No.

1. NAME OF DECEASED (Type or Print): Helen Haley
2. DATE OF DEATH: 1/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1005 Linden Ave. 11-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
F	C	Married	Jan. 13, 1915	33	1	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed	None	Lewis Del.	U.S.A.

13. FATHER'S NAME: Wm. Riley- Del
14. MOTHER'S MAIDEN NAME: Fannie Del

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	George Haley	1005 Linden Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rickets Malnutrition

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L. Royer M.D.		1/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/8/49	Mt. Calvary.	Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Huntington Williams, M.D.	A. WALSTEAD	(918 Druid Hill Ave.

VS 151

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G70251 BALTIMORE CITY HEALTH DEPARTMENT 420.0 G70251

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Catherine E. Burr
2. DATE OF DEATH: Jan-5-49
3. PLACE OF DEATH: A. Baltimore City, Maryland 104 N. Washington St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 75 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: City of Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 104 N. Washington St 6-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F.	W.	Widowed	8-7-1871	77	4	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Ky.	U.S.A.

13. FATHER'S NAME: John P. Thelen
14. MOTHER'S MAIDEN NAME: Anna M. Kuhn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Andrew T. Burr	104 N. Wash. St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular disease — DUE TO

(B) Cardiac Asthma — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 27 Sept, 1948 *to* 5 Jan, 1949, *that I last saw the deceased alive on* Jan 5, 1949, *and that death occurred at* 8:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Ellsworth Cook M. D.	2431 Maryland Ave	5 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-7-49	Holy Redeemer	4600 Beloir Rd. Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949		Riggel Bros.	1800 E. Lombard St

VS 150

937

H. P. Co.—1000 Blks. HOWARD 434.3 G70252

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 646 Dover St ST.: WARD)

2-FULL NAME Cecelia Howard

(a) RESIDENCE. No. 646 Dover ST. 22-2 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sandy Howard

6 DATE OF BIRTH (month, day, and year) 3-18-87

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 0

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Henry Frost

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Jane Cook

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co. Md (State or country)

14 Informant Sandy Howard (Address) 646 Dover St

15 JAN 6 1949 Huntington Williams M.D.

F.N. CARDOZO - M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5-49

17 I HEREBY CERTIFY, That I attended deceased from Dec 2-48 19 , to Jan 4-49 ,

that I last saw h Sm alive on , 19 ,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH was as follows:

Chron. Cardiac Disease

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senility debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F.N. Cardozo, M. D.

, 19 (Address) 524 W Hillsdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Eastern Cemetery Calvert Co Md	Jan 9. 1949
20 UNDERTAKER Joseph A. Sisly	ADDRESS 661 W Baltimore street.

95c

G70253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

581 D ✓

Registered No. G70253

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES (COMINGS) CUMMINGS

2. DATE OF DEATH January 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 749 Wilbur Court 17-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	married	1892	57 56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer	labor	Columbia, South Carolina	U.S.A.

13. FATHER'S NAME
Unknown

14. MOTHER'S MAIDEN NAME
Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	World War I		Emma Brad Cummings	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured Esophageal Varices — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cirrhosis of Liver

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil L Rogen			January 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/10/49	Balto National	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Huntington Williams, MD	Wm. A. Jackson	916 Penna Ave

VS 151

1243

G70254 BALTIMORE CITY HEALTH DEPARTMENT G70254
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) ~~O'SHAUGHNESSY~~ Mary O'Shaughnessy
2. DATE OF DEATH 1-4-49
3. PLACE OF DEATH: A. Baltimore City, Maryland ✓
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Balt. Balt. Md.
C. Length of stay in Baltimore Yrs. - Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 402 S. Wolfe Street 2-2
5. SEX ♀ 6. COLOR OR RACE wht 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 9/5/13 9. AGE (In years last birthday) 35 If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 10B. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Baltimore 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Poplar
14. MOTHER'S MAIDEN NAME Victoria ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Thomas O'Shaughnessy ADDRESS 402 S. Wolfe St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CHRONIC NEPHRITIS
DUE TO - ? UREMIA
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 12+ years

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 30, 1948 *to* Jan 4, 1949, *that I last saw the deceased alive on* Jan 4, 1949, *and that death occurred at* 3 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE Earl Carlisle S. Silverstein 23B. ADDRESS Sinai Hospital Balt Md 23C. DATE SIGNED 1-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 1/7/49 24C. NAME OF CEMETERY OR CREMATORY Holy Rosary 24D. LOCATION (City, town, or county) (State) German Hill Road B.MD.

DATE RECEIVED BY LOCAL REGISTRAR JAN 6 1949 REGISTRAR'S SIGNATURE Wellington Williams, M.D. 25. FUNERAL DIRECTOR Lilly & Zeiler ADDRESS 403 S. Wolfe St

VS 150

131B

G70255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70255

BIRTH NO. B.C. 48-26587

1. NAME OF DECEASED (Type or Print): ADA LOUISE ERVIN

2. DATE OF DEATH: January 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2010 East Baltimore Street 6-4 V

5. SEX	6. COLOR OR RACE	7. SINGLE, ~~MARRIED~~, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
female	white		12/6/48			30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore Md.	U.S.A.

13. FATHER'S NAME: Leland Ervin
14. MOTHER'S MAIDEN NAME: June Pusey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): None (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: June Ervin ADDRESS: 2010 E. Balto. St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Broncho-pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Paul L. Boyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: January 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/7/49	Meadowridge	Washington Blvd. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Lidy & Zuiler, Inc. 403 S. Wolfe St.

VS 151

8

107

G70256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

391.1 G.O.36

Registered No. BC-48-06722

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2501 W. Fayette St.
(c) Hospital or institution:

20

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 W. Fayette St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J. Nicholls

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1948

8. AGE: Years	Months	Days	If less than one day
	9	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Vernon R. Nicholls
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine C. Deegan
15. Birthplace Baltimore

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7th 1949 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore Md.

18 (a) Funeral director Gill Brothers
(b) Address 3189 Frederick Ave.

JAN 6 1949 Thurlington for Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1949, at 10:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5, 49. to Jan 6 1949.
and that I last saw him alive on Jan 5, 1949.

Immediate cause of death	Duration
Cerebellar Abscess, Possible	Hours
Due to Otitis Media, Rt - Acute exacerbation	2 days
Due to Otitis Media, Chron, with frequent acute attacks. Tonsillitis, Chron.	8 Months
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abram Goldman M. D.
Address 206 S. Gilmor St. Date signed Jan 6, 1949

VS 153

115c

G70257 ✓ #22-7 G70257

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Frank A. Steinert

2. DATE OF DEATH: Jan. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2324 E. Biddle St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2324 E. Biddle St. 8-4

c. Length of stay in Baltimore: 70 years (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	widowed	Aug. 12, 1869	81 79	4	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tool Grinder
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Otto Steinert
14. MOTHER'S MAIDEN NAME: Annie Vaulk
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-07-2613
17. INFORMANT: Mrs. Grace Makosky ADDRESS: 2324 E. Biddle St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Decompensation.
DUE TO
(B) Myocarditis.
DUE TO
(C) Acute Cardiac Failure.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 6, 1946 *to* Jan 3, 1949, *that I last saw the deceased alive on* Jan 3, 1949, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. A. Flamgan Jr. M.D. M. D.
23B. ADDRESS: 3503 Fait Ave.
23C. DATE SIGNED: 1-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/7/49	Baltimore	North Ave & Rose St.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1949
REGISTRAR: [illegible], M.D.
25. FUNERAL DIRECTOR: Clarence F. Hoffmann ADDRESS: 1639 Broadway

VS 150

93E

G70258

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70258

Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH A. VALENTINE

2. DATE OF DEATH: 1-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1120 N. Calvert St 11-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	S	6-19-77	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?		Balto Md	USA

13. FATHER'S NAME: Francis Valentine

14. MOTHER'S MAIDEN NAME: Mary Podesta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS (Street)
		Miss Katherine Valentine same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of tongue — INTERVAL BETWEEN ONSET AND DEATH: about 1 yr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-31-48 19 *to* 1-5- 19 49, *that I last saw the deceased alive on* 1-5- 19 49, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allyn F. Judd M. D.	Mercy Hospital	1-5-49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	1/8/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
	Huntington Williams, M.D.	H. D. Mears and Son 805 N. Calvert St.

VS 150

JAN 6 1949 1949

45B

G70259

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 9 7 2, 0-
N 7 6 4

Registered No. G70259

1. NAME OF DECEASED (Type or Print): WALTER ALLEN REYNOLDS

2. DATE OF DEATH: January 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

C. Length of stay in Baltimore: Yrs. - Mos. - Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2119 Wilkins Ave. 20-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	June 15, 1924	24 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Herbert A. Reynolds

14. MOTHER'S MAIDEN NAME: Lillian M. Elseroad

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): World War II

16. SOCIAL SECURITY NO.: 219-18-7009

17. INFORMANT: Mrs. Allen Reynolds - ADDRESS: 2119 Wilkins Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation due to

DUE TO

(B) Carbon Monoxide Poisoning

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARILY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2119 Wilkins Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 4, 1949 ? p.m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Oven and 4 burners on stove on but unlit (found with head in oven)

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 1-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/8/49

24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem.

24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1949

REGISTRAR'S SIGNATURE: [signature] Registrar for Baltimore, Md.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 151

163H

G70260 B.C. H-50604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70260 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LOIS Anne MUTH

2. DATE OF DEATH: Jan 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 309 Lyndhurst St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto, 29
D. STREET ADDRESS (If rural, give location): 20-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	July 4, 1946	2				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Louis P. MUTH
14. MOTHER'S MAIDEN NAME: Doris Ryder
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): -
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: -
17. INFORMANT: Hospital Records
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Glomerular nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Typoid nephrosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1949 *to* Jan 4, 1949 *that I last saw the deceased alive on* Jan 4, 1949 *and that death occurred at* 2 P.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Theodore C. Swinicki M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: Jan 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	1-7-49	Wrwid Ridge	Pikesville

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR: Wm J. Tickner & Sons
ADDRESS: Balto, Md.

VS 150

131B

G70261

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

223 G70261

Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS JOSEPH BIRMINGHAM

2. DATE OF DEATH: 1-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D STREET ADDRESS (If rural, give location): 19 Merrymount Rd. 27-13

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
M	W	married	April 19, 1916	32		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Twin City Supply		Balto	U-S.

13. FATHER'S NAME: Michael J. Birmingham

14 MOTHER'S MAIDEN NAME: Catherine A. Maley - 19 Merrymount Rd.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT ADDRESS
yes	served War II	-	Mrs. Barbara B. Birmingham -19 Merrymount Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acoustic neuroma — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acoustic neuroma

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-6-49	Neuroma, Acoustic	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____ 19__, *to* ____, 19__, *that I last saw the deceased alive on* 1-6, 19 49 *and that death occurred at* 12 05 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C DATE SIGNED
[signature] M. D.	Mercy Hosp.	1-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	1/8/49	Cathedral Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
JAN 6 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

56D

CERTIFICATE CORRECTED 1-8-49

G70262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70262

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elsie C. Strock alias Mary E. Williams (Mary Elizabeth Williams (Elsie C. Strock))

DATE OF DEATH 1/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 739 Newington Avenue 13-2

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Divorced	July 27, 1912	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waitress	Tavern	York Co., Pa.	U. S. A.

13. FATHER'S NAME Hugh F. Strock

14. MOTHER'S MAIDEN NAME Edith C. Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Baumeister's Funeral Home, York, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Fatty degeneration of liver

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
George G. Merrill M.D.		1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Jan. 6, 1949	Prospect Hill,	York, Pennsylvania

DATE RECEIVED BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Assistant Registrar Williams, M.D.	Loring Byers	5005 Old Harford Rd.

VS 151

13B

G70263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443

G70263

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Gladys Grilly.

2. DATE OF DEATH: 6 JAN. 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital
c. Length of stay in Baltimore: 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: PENN.
B. COUNTY: FRANKLIN
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WAYNESBORO
D. STREET ADDRESS (If rural, give location): 108 Tridle Ave

5. SEX: Fem
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 15 Dec 1880
9. AGE (In years last birthday): 68 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Mr John Powers
14. MOTHER'S MAIDEN NAME: Miss Sarah Gitkinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Husband — ADDRESS: Same as 4D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombosis of Abdominal Aorta — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Diabetes Mellitus & Arteriosclerosis

DUE TO

(C) Hypertensive Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 5 JAN 49
19B. MAJOR FINDINGS OF OPERATION: Embolectomy of Rt & Left Common Iliac Arteries
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 4, 1949, *to* Jan 6, 1949, *that I last saw the deceased alive on* Jan 6, 1949, *and that death occurred at* 2:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: T. F. Morrow M. D.
23B. ADDRESS: Church Home & Hosp.
23C. DATE SIGNED: Jan 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/49
24C. NAME OF CEMETERY OR CREMATORY: Waynesboro
24D. LOCATION (City, town, or county) (State): Waynesboro Pa

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949
REGISTRAR'S SIGNATURE: Thurlington W. Williams M.D.
25. FUNERAL DIRECTOR: R. J. Eamsheur — ADDRESS: Hedgesville W. Va.

61

70264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 70264

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Walter Reiser STAVELY

2. DATE OF DEATH: 4 January 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ferndale
D. STREET ADDRESS (If rural, give location): 16 Ferndale Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Married	8-7-02	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maintenance Worker	Furniture	Maryland	USA

13. FATHER'S NAME: Thomas Rhyer Stavely

14. MOTHER'S MAIDEN NAME: Maude Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unk.		Wife	Ferndale Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myocardial Infarction	
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* December 26, 1945, *to* January 4, 1949, *that I last saw the deceased alive on* January 4, 1949, *and that death occurred at* 5:50 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. Frank Suppler III M. D.	Union Memorial Hospital	Jan 4, 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1-7-49	Greenmount	Cumberland Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Huntington Rothauser, Md.	Harry H Witzke	4101 Edmondson

150

94a

0265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.0

Registered No. G70265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Dubeland
(c) Hospital or institution: West Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Ellen Atkinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/18/1871

8. AGE: Years 77 | Months 2 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Reinhold Harrison
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Atkinson
15. Birthplace Maryland

16 (a) Informant Edward Atkinson
(b) Address Sykesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/49 (month) (day) (year)
(c) Cemetery or crematory Mount View
Location Howard County

18 (a) Funeral director Harry C. Weyr
(b) Address Sykesville, Md.

JAN 7 1949
(Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1949, at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29/1948 to 1/6/1949 and that I last saw h[illegible] alive on 1/6/1949

Immediate cause of death Cardiac arrest — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard A. Holcomb, M.D.

Address WBGH Date signed 1/6/49

VS 150

937

G70266 E 316.1 N 403.0 ✓ G70266

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES A. MCGEEHAN
2. DATE OF DEATH: January 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: ~~Baltimore~~
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 2222 Lake Avenue 8-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Married	4/20/1889	59	8	16		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Paper
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: P. McGeehan
14. MOTHER'S MAIDEN NAME: Annie Cook
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-03-2019
17. INFORMANT: Nelta McGeehan ADDRESS: 2222 Lake Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull
DUE TO
(B) Intracranial Hemorrhage
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): public place
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Balto. Co. Taylor Ave. 2500 Ft. east of Lock Raven Blvd.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 5, 1949 2 p. m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? auto and truck collision

22. *I certify that I took charge of the remains described above, held* ~~an~~ a partial autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: January 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/8/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949
REGISTRAR'S SIGNATURE: [signature] for Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook ADDRESS: 27 St. Paul St. Balto. Md.

VS 151

170c

70267

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 912.4 N 903.0 ✓ G70267

Registered No.

1. NAME OF DECEASED (Type or Print) CHARLES H. (CARTER) CARDER	2. DATE OF DEATH January 4, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital c. Length of stay in Baltimore Yrs. Mos. Days	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 26-34 D. STREET ADDRESS (If rural, give location) 916 Shangler Way - Armistead Gardens
5. SEX Male 6. COLOR OR RACE White 7. SINGLE, ~~MARRIED, WIDOWED, DIVORCED~~ (Specify) Single	8. DATE OF BIRTH 11/12/1942 9. AGE (In years) last birthday) 6 If Under 1 Year: Months 1 Days 22 If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Va. 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Samuel Carder	14. MOTHER'S MAIDEN NAME Edna L. St. John 26-34
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Samuel Carder 916 Shangler Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Fractured skull	
	DUE TO with intracranial hemorrhage	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]
21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] ~~CAUSE~~ OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street--Public	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Pulaski Highway & Mapleton Avenue 26/44
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) January 4, 1949 3:15 p.m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE [signature] M.D.	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED 1-5-49
24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify) Burial	24B. DATE 1/7/49	24C. NAME OF CEMETERY OR CREMATORY Meadow Ridge 24D. LOCATION (City, town, or county) (State) Dorsey, Md
DATE RECEIVED BY LOCAL REGISTRAR JAN 7 1949	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR ADDRESS Wm Cook Inc. 1217 St. Paul St.

VS 151

170 C

268 ✓ 443 G70268

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302-W. Lexington St.
(c) Hospital or institution: Home of Our Lady
(d) Length of stay in hospital or inst. (yrs. mos. or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Tennant Way Balto. Md (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Sherman

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:
4. Sex: Fem
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 4-1874
8. AGE: Years 74 Months 8 Days 0 If less than one day hr. min.
9. Birthplace ? (Town, county, and state)
10. Usual Occupation Houseworker
11. Industry or business

MOTHER / FATHER
12. Name Patrick Clark
13. Birthplace Wisconsin
14. Maiden Name Sarah Tilden
15. Birthplace Wisconsin

16 (a) Informant Mrs Johanna Hawthorne
(b) Address 1302 W Lexington St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/49 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md
18 (a) Funeral director Wilson & Dorsey
(b) Address 1317 Druid Park
19 (a) JAN 7 1949 (Registered by Registrar) (b) Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1949 at 2.15 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1948 to Jan 3 1949 and that I last saw h alive on Jan 3 1949.

	Duration
Immediate cause of death: Acute Cardiac Dilatation	3 days
Due to: Hypertension Cardio Vascular disease	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harry Glassman M. D.
Address 75 3 W. Preston St Date signed Jan 4 49

VS 150

937

70269
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

A20.D

Registered No. G70269

1. NAME OF DECEASED (Type or Print): WINFIELD S. HELLMAN

2. DATE OF DEATH: 1-5-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 5701 Newholme Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 5701 Newholme Ave. 26-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	July 25th, 1880	68	5	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stationery Engineer	A.A. Chemical Co.	Baltimore, Md.	

13. FATHER'S NAME: William Hellman

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes Spanish American	214-01-7722	Mrs. Earl Bauer	Sparrows Box 257 R.F.D. 10

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — many years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-3, 1948, *to* 1-5, 1949 *that I last saw the deceased alive on* 1-4, 1949, *and that death occurred at* 5:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mark R. English M. D.	5713 Belair Rd.	1-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1/8/49	Parkwood	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Huntington Williams, M.D.	Lassahn Funeral Home	7401 Belair Rd.

VS 150

93D

AB-125467
70270

BALTIMORE CITY HEALTH DEPARTMENT 442 ✓ G70270
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Elsie George

2. DATE OF DEATH: Jan. 4-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 65 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 126 Churchill Street 22-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	Oct. 4- 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME: William Colbart or Colbort

14. MOTHER'S MAIDEN NAME: Helitha Hardy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Records-Baltimore City Hospitals- 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	2-3 wks
DUE TO (B)	Hypertensive-Arteriosclerotic Cardio-renal disease	2-3 yrs.
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No.	None	None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Dec. 19, 1948, *to* Jan. 4, 1949, *that I last saw the deceased alive on* Jan. 4, 1949, *and that death occurred at* 9:50 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. Steinman M. D.	Balto. City Hosp.	Jan-4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	1/7/49	LONDON PK	FREDERICK RD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Huntington for Matthews, M.D.	JOHN F. DENNY, INC	715 LIGHT ST - 30

VS 150

131a

BIRTH NO. 670271

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

322 ✓ Registered No. 670271

1. NAME OF DECEASED (Type or Print): Alice Rhone

2. DATE OF DEATH: Jan. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 625 W. Biddle Street 17-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Col.	Married	July 10, 1923	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	

13. FATHER'S NAME: George H. Rhone

14. MOTHER'S MAIDEN NAME: Alice Tennessee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Phillip Rhone	625 W. Biddle St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute alcoholism

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
George H. Merrill M.D.		1/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 7, 1949	Mt. Auburn Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Huntington Williams, M.D.	Mrs. Frances A. Hemsley	578 Biddle St.

77C

G70272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443 ✓

G70272

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Maggie Morris

2. DATE OF DEATH: Jan. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 415 W. Monument St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 415 W. Monument St. 11-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Widow	Dec. 15, 1893	55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: M's Nellie Derrick ADDRESS: 1505 Madison Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-vascular Disease & Decompensation.
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION: ------
19B. MAJOR FINDINGS OF OPERATION: ------
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ---
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1948, *to* Jan. 3, 1949, *that I last saw the deceased alive on* Dec 15, 1948, *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Herbert L. Bromley M. D.
23B. ADDRESS: 2024 Madison Avenue
23C. DATE SIGNED: 1/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-7-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mrs. Frances A. Hemsley ADDRESS: 578 W. Biddle St.

VS 150

937

G70273

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

002 ✓

Registered No. G70273

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Eleanor Thomas

2. DATE OF DEATH 1/4/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland 1025 Peach St

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
d. STREET ADDRESS (If rural, give location) 1025 Peach St. 22-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	Colored	Married	3/10/1921	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Baltimore, Md.	

13. FATHER'S NAME: ohn H. Jones

14. MOTHER'S MAIDEN NAME: Martha James

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Carroll Jones (1008	Peach St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Tuberculosis	7 months
	DUE TO (B)	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	over
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
no		YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 16, 1948 *to* Jan. 4, 1949 *that I last saw the deceased alive on* Jan. 4, 1949 *and that death occurred at* 5:08 *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Lincoln Shelton M. D.	908 E. Eager St.	1/7/49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1/8/49	Mt Auburn Ct.	Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Huntington Williams, M.D.	Isaiah L. Brown & Son	108 W. Montgomery St

VS 150

13B

G70274 ✓ H22.1 G70274

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) GEORGE H. GRESS

2. DATE OF DEATH Jan 5 - 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 2918 Westwood ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 2918 Westwood ave. 15-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male.	White	Widowed	May 3 - 1879	69	8	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Health Dept.	Clerk.	Baltimore Md.	Baltimore

13. FATHER'S NAME August Gress

14. MOTHER'S MAIDEN NAME Christine Hoffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. J. Howard Gress	N. Lyndhurst

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic cardio vascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 14, 19 48 *to* Jan 5, 19 49, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 1-20 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ernest H. Salen M. D.	1736 Poplar Gr St.	1/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 10-11 AM	Baltimore Cem.	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Courtesy Wm. Williamson, Mgr.	Mamie Cook Byfield	1600 W. North Ave.

VS 150

937

Pudam

G70275 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

570.5 ✓

G70275 — Registered No.

1. NAME OF DECEASED (Type or Print): Louis Pudam

2. DATE OF DEATH: 1-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2724 N Charles St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOCTORS-HOSPITAL

c. Length of stay in Baltimore: 45 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
b. COUNTY
823-HOLLINS ST.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
d. STREET ADDRESS (If rural, give location): 18-3.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	W	MARRIED	Unknown 1887	62 61	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TAILOR	SELF	LITHUANIA	

13. FATHER'S NAME: Carroll Pudam

14. MOTHER'S MAIDEN NAME: Anna Reinhardt.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO	—	—

17. INFORMANT: Mrs Anna Pudam — ADDRESS: 823 HOLLINS ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Acute Coronary Insufficiency	3 hrs
DUE TO		
(B)	Intestinal Obstruction Partial	8 days
DUE TO		
(C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-5, 1949 *to* 1-6, 1949, *that I last saw the deceased alive on* 1-6, 1949, *and that death occurred at* 10 55A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis J Sloan MD M. D.	876 Woodworth Blvd	1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	1/8/49	LOUDON PARK	3801 FREDERICK RD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Huntington Williams M.D.	JOHN J. COWAN & SON	981 HOLLINS ST

VS 150

940

70276 B.C. 49-10095 M 40.0 ✓ G70276

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Miller
2. DATE OF DEATH: Jan. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2334 Jefferson St.
C. Length of stay in Baltimore: 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2334 E. Jefferson St. 7-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W		Jan. 5, 1949.			2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	X	Md.	USA

13. FATHER'S NAME: John A. Miller
14. MOTHER'S MAIDEN NAME: Matilda Edna Meinschein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		NONE	Father	2334 E. Jefferson St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute hemolytic anemia	1 day
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Rh sensitivity	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 5, 1949, *to* Jan. 7, 1949, *that I last saw the deceased alive on* Jan. 6, 1949, *and that death occurred at* 7. A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. William Dorman Jr. M. D.	3101 St. Paul St., Baltimore, Md.	Jan. 7, 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 7/49	Oak Lawn Cem.	Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Huntington Williams, M.D.	John A. Miller	2334 Jefferson St

VS 150

731

G70277 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50.0 ✓ G70277 Registered No.

1. NAME OF DECEASED (Type or Print): LOUELLA GALLAGHER
2. DATE OF DEATH: I/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cold Spring Nursing Home
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Sunset Beach, Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Anne Arundel County
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	W	10/5/1872	76	2	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME: George Collins
14. MOTHER'S MAIDEN NAME: Ellen Elder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Family - 762 East Fort Avenue — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pneumonia	6 days
DUE TO (B)	Arteriosclerosis	10 yrs.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		over
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 6-1, 1948, *to* 1/4, 1949, *that I last saw the deceased alive on* 1/4, 19 49 *and that death occurred at* 6308 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Herman R Klemm M. D.
23B. ADDRESS: 3803 Edmondson Ave - 21
23C. DATE SIGNED: 1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	I/7/49	Cedar Hill	Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: James L. McCarney
ADDRESS: 130 E. Fort Ave

VS 150

107

G70278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

146

G70278

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Thomas W. Gantt

2. DATE OF DEATH: Jan. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1234 W. Lafayette Av

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. 7
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1234 W. Lafayette Ave K-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	Col.	M	Feb 28 1895	53 54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Calvert Co. Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Gantt

14. MOTHER'S MAIDEN NAME: Carrie White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-09-8103

17. INFORMANT: Mary Strand-Sister ADDRESS: 1234 Lafayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Abcess of Neck

DUE TO

(B) Carcinoma of throat

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(INTERVAL BETWEEN ONSET AND DEATH)

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Oct 19[illegible], *to* Jan 4, 1949, *that I last saw the deceased alive on* Jan 4, 1949, *and that death occurred at* 3 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Douglas Sheppard M. D.

23B. ADDRESS: 604 N. Fulton Ave

23C. DATE SIGNED: 1-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 9-49

24C. NAME OF CEMETERY OR CREMATORY: Brooks Chapel

24D. LOCATION (City, town, or county) (State): Calvert Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: James A Stayer ADDRESS: 45F

VS 150

70279

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 174

Registered No. 70279

1. NAME OF DECEASED (Type or Print) ELIZABETH G BROWN

2. DATE OF DEATH Jan.5,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
5525 Gwynn Oak Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
5525 Gwyn Oak Ave.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore,Md.
D. STREET ADDRESS (If rural, give location)
5525 Gwynn Oak Ave. 28-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widow	Jan.6.1871	77	11	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore County, Md.	

13. FATHER'S NAME
Andrew J. Giffin

14. MOTHER'S MAIDEN NAME
Christina Harn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	None	Mrs Hilchreth Bowman	5525 Gwynn Oak Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Primary Carcinoma of Uterus — INTERVAL BETWEEN ONSET AND DEATH: 2 ½ yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) - Uterus - Sclerotic Heart Disease.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1946.	- Cancer of Uterus	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 14, 1948, *to* Jan - 5, 1949, *that I last saw the deceased alive on* Jan - 5th, 1949, *and that death occurred at* 3.9 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Earl L. Chambers M. D.	4108 Liberty Hts Ave.	1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan.7,1949	Lorraine Park	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Hunting Tow Williams, M.D.	William Cook, Inc.	1217 St. Paul St.

VS 150

48B

70280 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70280 Registered No.

1. NAME OF DECEASED (Type or Print): Mr. Joseph William Manke

2. DATE OF DEATH: January 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Life 32 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland Overlea
D. STREET ADDRESS (If rural, give location): 8 McCormick Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	May 4, 1916	32	8	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Steelmill Worker	Sparrows Point	Baltimore, Maryland	

13. FATHER'S NAME: Henry Manke

14. MOTHER'S MAIDEN NAME: Louise Solbach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: wife — ADDRESS: 8 McCormick Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 12 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute glomerulo-nephritis — 1 month

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 27, 1948 *to* Jan 6, 1949, *that I last saw the deceased alive on* Jan 6, 1949, *and that death occurred at* 3:03 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ray E. Parsons Jr. M. D.	11 Osprey Rock.	1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-10-49	Holy Redeemer	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 7 1949	Huntington Williams, M.D.	L. J. Luck — 5305 Harford Rd.

HS 150

95c

70281 BALTIMORE CITY HEALTH DEPARTMENT H50.0 ✓ G70281
CERTIFICATE OF DEATH Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jessie D. Johnson
2. DATE OF DEATH: 1-6-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Franklin Sq Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq. Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt.
D. STREET ADDRESS (If rural, give location): 4507 Hampnett Ave 27-2

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Oct 26, 1888
9. AGE (In years last birthday): 60 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Balt. Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Westley Gadd
14. MOTHER'S MAIDEN NAME: Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Maynard Johnson ADDRESS 4507 Hampnett Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Thrombosis of vertebral artery left — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
(B) Arteriosclerotic vascular disease — years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION: as above.
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1 1949 to 1-6 1949 that I last saw the deceased alive on 1-6 1949 and that death occurred at 2 46 p m., from the causes and on the date stated above.

23A. SIGNATURE: A. J. Laham M. D.
23B. ADDRESS: Franklin Sq. Hosp.
23C. DATE SIGNED: 1-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-8-49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949
REGISTRAR'S SIGNATURE: Lexington Williams M.D.
25. FUNERAL DIRECTOR: L. J. Luck ADDRESS: 5305 Harford Rd.

VS 150

9-D

CERTIFICATE CORRECTED 2-24-49

G70282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70282

BIRTH NO.

1. NAME OF DECEASED (Type or Print)	GEORGE	KRUGER	2. DATE OF DEATH: January 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
c. Length of stay in Baltimore: 3 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington DC
D. STREET ADDRESS (If rural, give location): 2715 Woodley Place N.W

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	12-1-1924	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student		Washington DC	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamin Kruger	Sophie Klotzkein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
(NO)	11-13-46 to 10-22-46	577-24-310	Benj Kruger 2715	Woodley Pl Wash

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

DUE TO

(B) Intracranial Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street--public	1½ miles south of Little Gunpowder Falls, Routh #40.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
1-4-49 m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Auto and Trailor Truck Collision

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER [X] / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Emil L. Kruger M.D.		1/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-9-49	Ohev Sholem	Washington DC

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Place

VS 151

170c

BC-48-27239

G70283 BALTIMORE CITY HEALTH DEPARTMENT 772.0 ✓ G70283

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Mary Kathleen Lynch

2. DATE OF DEATH: 1/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital - 1213 Light Street
C. Length of stay in Baltimore: 3 weeks (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1318 S. Charles Street 23-1

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec. 11, 1948
9. AGE (In years last birthday): If Under 1 Year: Months / Days: 25 / If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles L. Lynch
14. MOTHER'S MAIDEN NAME: Mary R. Jones
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS ✓

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia and Acidosis
DUE TO
Unable to state
(B) Malnutrition and Diarrhea - 2 days
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Dehydration

INTERVAL BETWEEN ONSET AND DEATH: day / 1 week

CERTIFICATION APPROVED BY
For: Wm. G. Helfrich, M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/5/49 19 , *to* 1/5/49 , 19 , *that I last saw the deceased alive on* 1/5/49 , 19 , *and that death occurred at* 10[45] P m., *from the causes and on the date stated above.*

23A. SIGNATURE: William J. Hamm, M. D.
23B. ADDRESS: South Baltimore Gen. Hospital
23C. DATE SIGNED: 1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/8/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. J. Fahey
ADDRESS: Linthicum

VS 150

119a

Hal 7 G70284 BALTIMORE CITY HEALTH DEPARTMENT G70284

CERTIFICATE OF DEATH

E 90 3.0-935.0 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice B. Knoerlein

2. DATE OF DEATH: JAN 6 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 74 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 430 N. Rose St 6-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	4-4-74	74 years		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ? Russell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
(A)	Cardiac Decompensation	chronic
DUE TO		
(B)	Senility & Fracture of left Hip	9 days
DUE TO		
(C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
29 Dec 48	fracture left hip intertrochanteric	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home	430 N Rose st 6/2

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
27 Dec 48 1 00 a m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Simple fall at home (Slipped and fell to floor)

22. *I hereby certify that I attended the deceased from* 12-27-1948 *to* 1-6-1949, *that I last saw the deceased alive on* 1-6-1949, *and that death occurred at* 3 20 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. K. Kerneran M. D.	JOHNS HOPKINS HOSPITAL	1-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-10-49	Holy Redeemer	4600 Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Huntington Williams, M.D.	Deppel Bros.	1800 E Lombard St.

VS 150

186a

GM. 125805 B.C. 48-24188

BIRTH NO. G70285

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

204.1 G70285 Registered No.

1. NAME OF DECEASED (Type or Print): Wanda Lee Brookman

2. DATE OF DEATH: Jan. 7-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland MD.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3844 Falls RD. 12-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	S	Oct. 30 1948	2 MO.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Jess
14. MOTHER'S MAIDEN NAME: Hester Perryman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Records Balto. City Hospital ADDRESS 4940 Eastern A

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Myelogenous Leukemia
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Anemia Septicemia Infect. Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH: month? 6 days.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 5, 1949 *to* Jan 7, 1949, *that I last saw the deceased alive on* Jan 7, 1949, *and that death occurred at* 1.40 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	Balto City Hosp	Jan 7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/8/49	St. Mary's.	Hampden.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
	Huntington Williams, M.D.	Paul E. Chenoweth Jr-3615-17	Chestnut Ave.

VS 150

157E

70286

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 70286

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Ingleside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lotta Taylor

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife William C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 21-1897

8. AGE: Years 51 | Months 9 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Alfred Hanley
13. Birthplace Md
14. Maiden Name Gertrude Kerby
15. Birthplace Md

16 (a) Informant Mr. Wm. C. Taylor
(b) Address 1418 Ingleside ave

17 (a) Burial (b) Date thereof Jan 9-49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Balto. Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1512 Collins St

19 (a) JAN 7 1949 (b) Huntington-Williams Mort
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3 1949 at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 19... to 19...
and that I last saw her alive on 1/3 1949.

Immediate cause of death: Cardio-Respiratory failure — Secondary to Carcinoma — Duration: [illegible]
Due to: Brain Tumor rt. Temporal lobe — Duration: [illegible]
Due to: — Duration: [illegible]
Other Conditions — Duration: [illegible]
(Include pregnancy within 3 months of death)

Date of operation 12/10/48
Major findings of operation: Brain tumor rt. temporal lobe
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. H. Running
Address St. Agnes Hospital Date signed 1/3/49 M. D.

54a

VS 150

G70287 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

A50.0 ✓ G70287 Registered No.

1. NAME OF DECEASED (Type or Print): Howard A. Moore
2. DATE OF DEATH: JAN. 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 530 E. 35th ST
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 530 E. 35th ST 9-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	MARRIED	MAY 22, 1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: A. B. MOORE
14. MOTHER'S MAIDEN NAME: LAURA KIRWAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: MARGARET C. MOORE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) General arteriosclerosis	
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 4, 1948, *to* Jan 5, 1949, *that I last saw the deceased alive on* Jan 5, 1949, *and that death occurred at* 7.00 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm Dehuff M. D.
23B. ADDRESS: 701 N. Linwood Ave.
23C. DATE SIGNED: 1/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	1-8-49	BALTIMORE Cem.	BALTIMORE Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: John A. Mosan — 3000 E. Balt. St

VS 150

97

G70288 BALTIMORE CITY HEALTH DEPARTMENT #20.1 ✓ G70288

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Lorette Marie Dolan
2. DATE OF DEATH: 1-7-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 302 Chancery Rd. 12-1
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 5-26-81
9. AGE (In years last birthday): 67. If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.
10B. KIND OF BUSINESS OR INDUSTRY: None.
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Patrick O'Connell
14. MOTHER'S MAIDEN NAME: Elizabeth Lovelle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Peter F. Dolan ADDRESS: 302 Chancery Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Disease — —

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Cholecystitis & Cholelithiasis

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-6 1949, *to* 1-7, 1949, *that I last saw the deceased alive on* 1-7, 1949, *and that death occurred at* 1 45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John T. Russell M. D.
23B. ADDRESS: St. Joseph Hosp.
23C. DATE SIGNED: 1/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-10-49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Old Frederick Rd Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Mason ADDRESS: 3000 E. Balt

VS 150

937

70289

BALTIMORE CITY HEALTH DEPARTMENT ✓ 420.0 Registered No. 70289

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland Sts
(c) Hospital or institution: West Balto Gen Hosp-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
16-4
(d) Street No. 1132 McKean Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Anna Tawney

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
F	W	widowed

6 (b) Name of husband or wife Hurst Clayton Tawney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1896

8. AGE: Years	Months	Days	If less than one day
52	8	17	hr. min.

9. Birthplace Westminster Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Wagner
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline R. Horton
15. Birthplace Md.

16 (a) Informant Miss Elizabeth Tawney
(b) Address 1132 McKean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/49 (month) (day) (year)
(c) Cemetery or crematory Leisters Cem.
Location Westminster, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 7 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1949 at 3:44 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11/10/1948 to 1/6/1949 and that I last saw h~~im~~ alive on 1/6/1949.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to Congestive Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard A. Golombeck
Address WB 64 Date signed 1/7/49

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927

70290

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581.1

G70290

Registered No.

1. NAME OF DECEASED (Type or Print): FRANCIS PATRICK KELLY

2. DATE OF DEATH: 6 Jan. 48 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 2842 Woodbrook Ave. 12-4

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: Jan. 2, 1890

9. AGE (In years last birthday): 59
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10B. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis J. Kelly

14. MOTHER'S MAIDEN NAME: Mary A. McCartney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: no

17. INFORMANT: Miss Margaret Kelly
ADDRESS: 2842 Woodbrook Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic alcoholism

DUE TO

(B) Ascites, pulmonary edema &

DUE TO

(C) Cirrhosis of Liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3 Jan 1949 *to* 6 Jan 1949 *that I last saw the deceased alive on* 6 Jan 1949 *and that death occurred at* 10 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Robert Liberto M. D.

23B. ADDRESS: Bon Secours Hospital

23C. DATE SIGNED: 6 Jan. 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial,

24B. DATE: 1/10/49

24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS

ADDRESS: Balto., Md.

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124a

70291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H 20.1

Registered No. 070291

BIRTH NO.

1. NAME OF DECEASED (Type or Print): REV. THOMAS DAVID WILLIAMS

2. DATE OF DEATH: Jan. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp.
c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): Bon Secours Hosp. 32-1

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: July 11, 1872
9. AGE (In years last birthday): 76 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Priest
10B. KIND OF BUSINESS OR INDUSTRY: Religious
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas Williams
14. MOTHER'S MAIDEN NAME: Honorine Wanda
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mr. Francis P. Williams — ADDRESS: 80 Dartmouth Rd. Dedham, Mass.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 11, 1938 *to* Jan 6, 1949 *that I last saw the deceased alive on* Jan. 6, 1949 *and that death occurred at* 11.45 *Am., from the causes and on the date stated above.*

23A. SIGNATURE: O. F. Shohler M. D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/8/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet, Wash., D.C.
24D. LOCATION (City, town, or county) (State): Washington, D. C.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949
REGISTRAR'S SIGNATURE: Tuttington Williams, MD
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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94a

G70292 BALTIMORE CITY HEALTH DEPARTMENT G70292
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Margaret Smith
2. DATE OF DEATH: 1/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Found drowned East Side of Recreation Pier Foot of St. Anns St.
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3201 Esther Place 26-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	Feb. 14, 1906	42 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Auer
14. MOTHER'S MAIDEN NAME: Catherine Kearns
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mr. Harry A. Smith ADDRESS: 3201 Esther Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Drowning
DUE TO
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: History of mental depression.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Recreation Pier Foot of St. Anns St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1/6/49 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Unknown — Found drowned

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/10/49	New Cathedral Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949
REGISTRAR'S SIGNATURE: Winston Von Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Baltimore Md.

VS 151

164B

G70293
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

31 ✓

G70293
Registered No.

1. NAME OF DECEASED (Type or Print) Mary Theresa Robinson

2. DATE OF DEATH 1/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2621 Hampden Ave
C. Length of stay in Baltimore 50 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2621 Hampdem Ave 12-7

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 3/25/1871
9. AGE (In years last birthday) 77 (If Under 1 Year: Months 9, Days 10; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto. Co.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Barron
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never, unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO None
17. INFORMANT Elizabeth A. Robinson ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Cerebral and general — 2
DUE TO
(C) Arteriosclerosis.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Nov. 16, 1947, *to* Jan 5, 1949, *that I last saw the deceased alive on* Jan. 6, 1949, *and that death occurred at* 12 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE W. H. Smith M. D.
23B. ADDRESS 3429 Chestnut Ave.
23C. DATE SIGNED Jan 6-49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/10/49
24C. NAME OF CEMETERY OR CREMATORY Cathedral
24D. LOCATION (City, town, or County) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR JAN 7 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Charles F. Evans & Son ADDRESS

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83a

G70294 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

442

G70294 — Registered No.

1. NAME OF DECEASED (Type or Print): Ella Louise Curtain

2. DATE OF DEATH: 1/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1537 Aliceanna St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1537 Aliceanna St. 3-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	1/13/1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.

13. FATHER'S NAME: George Clarkson

14. MOTHER'S MAIDEN NAME: Josephine Wolfe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
None	None	Mrs. Wilbert Behner	1537 Aliceanna St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)		
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	CONGESTIVE CARDIO-VASCULAR RENAL DISEASE	5 WEEKS
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
NONE	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 27 1948 *to* JAN. 5, 1949 *that I last saw the deceased alive on* JAN. 5, 1949 *and that death occurred at* 5:40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE, M. D.	23B. ADDRESS	23C. DATE SIGNED
Joseph F Luenga	209 S. Chester St	1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/8/49	Sacred Heart	German Hill Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Huntington Williams, MD	Lilly & Zeiler, Inc.	403 S. Wolfe St.

VS 150

1312

G70295 BALTIMORE CITY HEALTH DEPARTMENT 420-1 G70295

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) OCHS, ALFRED L

2. DATE OF DEATH 1-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSP.

c. Length of stay in Baltimore Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 4802 WRIGHT AVE 26-34

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W		AUG 31 1887	61	4	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
REPRESENTATIVE	MANOFACTURY	PENNSYLVANIA	

13. FATHER'S NAME MILTON T. J. OCHS

14. MOTHER'S MAIDEN NAME LOUISA OPPENLANDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis with
DUE TO Acute Circulation, renal
(B) Thrombi, Pulmonary
DUE TO Embolism
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
12-28-48 TO 1-7-49

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-28, 1948 *to* 1-7, 1949 *that I last saw the deceased alive on* 1-7, 1949 *and that death occurred at* 310 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Carlie R Marschner M. D.	Univ. Hosp.	1-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
REMOVAL	1/8/49	FAIRVIEW	ALLENTOWN PA.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTERED BY	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	[illegible]	Wm Cook Jr.	1217 St Paul St.

VS 150

94a

G70296

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

416 ✓

Registered No. G70296

1. NAME OF DECEASED (Type or Print): HENRY CHARLES STEIGELMAN

2. DATE OF DEATH: 1-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5200 Wright Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 5023 E. PRESTON 26-44

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White		OCT 8 1945	3	2	30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: HENRY STEIGELMAN
14. MOTHER'S MAIDEN NAME: CATHERINE HAHN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: HENRY STEIGELMAN ADDRESS: 5023 E. PRESTON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Upper respiratory infection — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR
23C. DATE SIGNED: 1/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: 1/8/49
24C. NAME OF CEMETERY OR CREMATORY: VAL HOLLOW
24D. LOCATION (City, town, or county) (State): N.Y. N.Y.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

104a

G70297 X 810 ✓ G70297

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): George Boyd

2. DATE OF DEATH: 1-6-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hospital Broadway - Fairmount Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Florida
B. COUNTY: Broward
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Lauderdale
D. STREET ADDRESS (If rural, give location): 504 Southeast 9th St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 11 1889
9. AGE (In years last birthday): 59
If Under 1 Year: Months 10 Days 25
If Under 24 Hours: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Canada
12. CITIZEN OF WHAT COUNTRY? Canada

13. FATHER'S NAME: George Boyd
14. MOTHER'S MAIDEN NAME: Ellen MacDonald

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: MRS. FRANK BOYD ADDRESS: NIAGARA FALLS, ONTARIO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of Liver
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Pancreatic Stone + Pancreatic Atrophy Myocardial degeneration + Mural

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Thrombus, Ascites + Pulmonary Edema

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 12-30-48
19b. MAJOR FINDINGS OF OPERATION: Cirrhosis of Liver
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 18 *,* 1948 *to* Jan 6 *,* 1949 *that I last saw the deceased alive on* Jan 6 *,* 1949 *, and that death occurred at* 10 45 p *m., from the causes and on the date stated above.*

23a. SIGNATURE: T. Leary Morrow M. D.
23b. ADDRESS: Church Home + Hosp.
23c. DATE SIGNED: Jan 7 1949

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24b. DATE: 1/7/49
24c. NAME OF CEMETERY OR CREMATORY: NIAGARA FALLS
24d. LOCATION (City, town, or county) (State): ONTARIO CANADA

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1949
REGISTRAR'S SIGNATURE: Evelyn Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St Paul St

JAN 150

124 B

G70,298 331 G70,298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clarisse B. Jehan

2. DATE OF DEATH: Jan. 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2619 Guilford Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): -------

c. Length of stay in Baltimore: 9 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2619 Guilford Avenue 12-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Dec. 18, 1865	83	0	17	--	--

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Linard, France	

13. FATHER'S NAME: Pierre Barbu

14. MOTHER'S MAIDEN NAME: Marie Jelland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	----------	-------	Mrs. Louise Kearney	2619 Guilford Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteriosclerosis with Hypertension	2 yrs (?)
DUE TO (B)	Cerebral Hemorrhage	6 days
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 30, 1948 *to* 5th, 1949 *that I last saw the deceased alive on* 1/5, 1949 *and that death occurred at* 1:30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P. W. Hom M. D.	11 E. Chase St	1-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/8/49	New Cathedral	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 7 1949	Huntington Williams, M.D.	H. W. Meeks and Son	805 N. Calvert St.

VS 150

832

70:299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered 70:299

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4212 Parkmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Massway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Enos M. Mercer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wh	Wid

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business B&O R.R.

FATHER
12. Name George W. Mercer
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Waldon
15. Birthplace Va

16 (a) Informant Mrs Cynthia Mercer
(b) Address 262 Massway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9 1949 (month) (day) (year)
(c) Cemetery or crematory Mount Stone Baptist Ch
Location Mount Stone Dr.

18 (a) Funeral director John C Moran
(b) Address 3001 Baltimore Blvd

19 (a) JAN 8 1949 (b) Washington Hollis Registrar
(Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1949 at 10:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1949 to Jan. 7 1949 and that I last saw him alive on Jan 6 1949.

Immediate cause of death	Duration
Congestive Heart Failure	1 day.
Due to Chronic Myocarditis	5 yrs.
Due to Arteriosclerosis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael J. Donnelly
Address 1 W. Lanvale Ave Date signed 1-7-49 (M. D.)

VS 150

937

G70300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#907 (1775)

G70300

BIRTH NO. B.C. 48-25339 Registered No.

1. NAME OF DECEASED (Type or Print): Angelus Wright

2. DATE OF DEATH: 1/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.
C. Length of stay in Baltimore: Yrs. & Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 340 Childs Court 5-6

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 11/1/48
9. AGE (In years last birthday): If Under 1 Year: Months 2, Days 1 / If Under 24 Hours: Hours 6, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Louis Wright
14. MOTHER'S MAIDEN NAME: Ruth Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT / ADDRESS: South Balto. General Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar pneumonia rt. upper lobe and pertaining both lower lobes. Probably due to or R.S.F.

DUE TO (B) Atelectasis left upper lobe, due probably to mucus plug.

DUE TO (C) Prematurity.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 1-4-49 9:30 pm
(B) 1-6-49 a.m. at 9 am

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/4 *, 19*49*, to* 1/6 *, 19*49 *that I last saw the deceased alive on* 1/6 *, 19*49 *and that death occurred at* 9 45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: South Baltimore General Hospital
23C. DATE SIGNED: 1/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/8/49
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county): Baltimore (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR / ADDRESS: Wilson Co. Inc. 1219 Cook St

VS 150

108

0301 — BALTIMORE CITY HEALTH DEPARTMENT — G20301

CERTIFICATE OF DEATH

BIRTH NO. — Registered No. G20301

1. NAME OF DECEASED (Type or Print): MRS. EMMA K. DUGDALE

2. DATE OF DEATH: 1/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME AND HOSPITAL
c. Length of stay in Baltimore — Yrs. Mos. Days: LIFE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1231 CARROLL ST. 21-2

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: APRIL 26 1868
9. AGE (In years last birthday): 80 79 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE MD
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOSEPH MILLER
14. MOTHER'S MAIDEN NAME: ANNA BONDARES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: CHURCH HOME AND HOSPITAL — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Cerebral vascular accident
(B) DUE TO: Arteriosclerotic Heart Disease grade IV / Arteriosclerotic Hypertension grade IV
(C) Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/30, 1948, to 1/6, 1949 *that I last saw the deceased alive on* 1/6, 1949 *and that death occurred at* 7:40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Donald V. Mintz M. D.
23B. ADDRESS: Church Home + Hosp
23C. DATE SIGNED: 1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/49
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Butler Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR — ADDRESS: Wm Cook Inc. 1217 St. Paul St. Balto. Md.

VS 150

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70302 B.C. H-95974 ✓ 591.0 G70302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) BARBARA MARTIN

2. DATE OF DEATH Jan. 7/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Sinai Hos

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hos.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE B. COUNTY 3230 Lyndale Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 3230 Lyndale Ave 8-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White		Dec. 9 1947	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Baltimore	—

13. FATHER'S NAME Melton Martin

14. MOTHER'S MAIDEN NAME Genevieve Gmurek ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—		Melton Martin	3230 Lyndale

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Gastro Enteritis

DUE TO Undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiac Failure

DUE TO Undetermined

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 days.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1948, *to* Jan 7, 1949, *that I last saw the deceased alive on* Jan 7, 1949, *and that death occurred at* 7:40 AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sydney A. Warren M. D.	Sinai Hospital	Jan 7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county)	(State)
Burial	Jan. 8/49	Holy Redeemer	Baltimore	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 8 1949	Huntington Williams M.D.	Fred W. Ozarowski 1930	Eastern Ave

VS 150

1190

G70303

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

180 ✓

G70303 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret Damerlock

2. DATE OF DEATH: 1-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 55 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2922 Winchester St. 16-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	Feb. 23 1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Maryland	

13. FATHER'S NAME: Herod Tighman

14. MOTHER'S MAIDEN NAME: Sarah E. Nash

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No — No	None	Susanna M Whitehead	2922 Winchester St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized carcinomatosis & — INTERVAL BETWEEN ONSET AND DEATH: 87 days (Hosp.) 7 mo.

DUE TO bone metastases

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypernephroma

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 2, '48	Metastatic carcinoma of cord	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 13, 1948 *to* Jan 7, 1949 *that I last saw the deceased alive on* Jan 6, 1949 *and that death occurred at* 12:10 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred R. McGuire Jr. M. D.	Unversity Hosp.	1/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 10 1949	Asbury Cemetery	Reisterstown, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 8 - 1949	Huntington Williams, M.D.	Ellis Amoreau	4510 Liberty Heights Ave

VS 150

52a

G70304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1

G70304

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles T. Cameron

2. DATE OF DEATH: January 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3709 Milford Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland, B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 3709 Milford Ave. 28-1

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 23, 1876
9. AGE (In years last birthday): 72 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Wiseman & Downs
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Cameron
14. MOTHER'S MAIDEN NAME: Ellen Peelman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-05-5603
17. INFORMANT ADDRESS: Mrs. Rosa A. Cameron, 3709 Milford Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.
DUE TO
(B) Arteriosclerotic Heart Disease — 10 yrs.
DUE TO
(C) Bronchial Asthma & Chronic Bronchitis — 10 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 10, 1933, *to* Jan. 5, 1949, *that I last saw the deceased alive on* Jan. 5, 1949, *and that death occurred at* 10.45P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Earl L. Chambers, M. D.
23B. ADDRESS: 4108 Liberty Heights Ave.
23C. DATE SIGNED: 1/5/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 8, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
24D. LOCATION (City, town, or county) (State): Frederick, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1949
REGISTRAR'S SIGNATURE: Cuntis for Williams, M.D.
25. FUNERAL DIRECTOR: Gilbert Donovan
ADDRESS: 4510 Liberty HgtsAve.

VS 150

937

70305 J1- 125864

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160 ✓

G70305

Registered No.

1. NAME OF DECEASED (Type or Print): Stephen George

2. DATE OF DEATH: Jan. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 5 hrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1023 Forrest St. 10-1

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 4, 1882
9. AGE (In years last birthday): 66 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Window Cleaner
10B. KIND OF BUSINESS OR INDUSTRY: Nat. Window Cleaning
11. BIRTHPLACE (State or foreign country): Md. (Baltimore)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Stephen H. George
14. MOTHER'S MAIDEN NAME: ? Emma Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: 216-07-4767
17. INFORMANT ADDRESS: 4940 Eastern Ave. Baltimore City Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Shock, Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of nose c metastasis — 3 months

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1·6·· 19[illegible]9 *to* 1·7 , 19[illegible] *that I last saw the deceased alive on* 1·7· , 19[illegible]9 *and that death occurred at* 4:25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Clyde A. Pickles M. D.
23B. ADDRESS: 4940 Eastern Ave
23C. DATE SIGNED: 1·7·49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 1/10/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. Miller Amoroso
ADDRESS: 4510 Liberty Heights Ave

VS 150

53

G70306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

A25-1

G70306

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Ida C. Barron

2. DATE OF DEATH: Jan. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 233 S. East Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 233 S. East Ave. 26-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Aug. 20, 1869	79	4	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Harmon Reseu
14. MOTHER'S MAIDEN NAME: Sophia Knapp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Eleanor G. Barron ADDRESS: 233 S. East Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Infirmities of Old Age

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: 2 months

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1 1948 *to* 1/6 1949 *that I last saw the deceased alive on* 1/6 1949 *and that death occurred at* 1:30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Dwight F. Tubbs M. D.
23B. ADDRESS: 3332 Balto St
23C. DATE SIGNED: 1/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 10, 1949
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ullrich Funeral Home ADDRESS

VS 150

94a

70307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

G70307

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Michael Sturmer.

2. DATE OF DEATH: 1-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp.
c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3303 E. Baltimore St. 26-10

5. SEX: Male.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 12-29-81
9. AGE (In years last birthday): 67. If Under 1 Year: Months / Days. If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): B.T.Co. Road Checker
10B. KIND OF BUSINESS OR INDUSTRY: Transit Works.
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Albert E. Thompson. ADDRESS: 3303 E. Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of splenic flexure of colon	?
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Pneumonia with abscess - right	4 days

19A. DATE OF OPERATION: 12-21-48
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of splenic flexure - colon
20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-18, 1948 *to* 1-7, 1949 *that I last saw the deceased alive on* 1-7, 1949, *and that death occurred at* 2:34 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John T. Everett M.D.
23B. ADDRESS: St. Joseph's Hosp.
23C. DATE SIGNED: 1-7-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 10/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Balto Co.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Uhl Funeral Homes ADDRESS: 2008 Eden

VS 150

46E

G70308 B.C. 48-18973

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

954.6

Registered No. G70308

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 Carswell street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
9-7
(d) Street No. 1720 Carswell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Martin Kleszynski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep. 4 1948

8. AGE: Years | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Thomas Kleszynski

13. Birthplace Balto. Md.

14. Maiden Name Celslawa Kowalski

15. Birthplace Wilmington Delaware

16 (a) Informant Thomas Kleszynski

(b) Address 1720 Carswell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8 1949 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Balto. County

18 (a) Funeral director Mrs Mary Weber

(b) Address 401 S. Chester Street

19 (a) JAN 8 - 1949 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1949, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1948 to Jan 6 1949 and that I last saw him alive on Jan 6 1949

Immediate cause of death Pneumonia, broncho

Due to Bronchitis.

Due to Mal development of bones of face and mucho

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
[illegible]
Dec 14
Jan 6
Life

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Lyman Mettle M. D.

Address 1229 N. Calvert St Date signed

VS 150

107

70309

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70309
Registered No.

1. NAME OF DECEASED (Type or Print): Mary Gibson

2. DATE OF DEATH: Jan. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Garrison Nursing Home 2803 Garrison Blvd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Mary land
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2805 Northern Parkway 27-7

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Apr. 14, 1878
9. AGE (In years last birthday): 70 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: George Vogt
14. MOTHER'S MAIDEN NAME: Anna Borcherding
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. G. E. Sinclair, ADDRESS: 2805 Northern Pkwy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hemorrhage Cerebral	36 hrs
DUE TO (B)	Hypertension	years
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Arteriosclerosis	years
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Previous Cerebral Hemorrhages (many)	

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June 1 *1948 to* Jan 5 *, 1949 that I last saw the deceased alive on* Jan 5 *, 1949, and that death occurred at* 8 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: B J Mendeles M. D.
23B. ADDRESS: 651 N Bentalou
23C. DATE SIGNED: 1/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-8-49
24C. NAME OF CEMETERY OR CREMATORY: Trinity
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Ruck, ADDRESS: 5305 Harford Rd.

VS 150

R3a

BIRTH NO. 670310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

H 20.1

Registered No. 670310

1. NAME OF DECEASED (Type or Print): JOSEPH A. CASCIO

2. DATE OF DEATH: January 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2807 West Lafayette Avenue 16-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Oct 13, 1903	45	2	24

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic B.T.C.

10B. KIND OF BUSINESS OR INDUSTRY: Balto Transit Co

11. BIRTHPLACE (State or foreign country): Balto

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Cascio (Italy

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: James A. Cascio ADDRESS: 2807 W Lafayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: January 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE: 1/10/49

24C. NAME OF CEMETERY OR CREMATORY: Green Cath -

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Leonard J Ruck ADDRESS: 6305 Naylor Rd

VS 151

940

70311 420.0 ✓ G70311

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Lydia M. Link

2. DATE OF DEATH: Jan. 6th, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 938 Gorsuch Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 938 Gorsuch Ave 9-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Aug. 18, 1884	64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher	Retired	Baltimore, Md	U. S.

13. FATHER'S NAME: Godfrey A. Link

14. MOTHER'S MAIDEN NAME: Zalinda Russell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Miss Loretto Link	938 Gorsuch Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Arteriosclerotic Cardio-Vascular disease with Hypertension. — 1 yr.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 3, 1948 *to* Jan. 6, 1949 *that I last saw the deceased alive on* Jan. 3, 1949 *and that death occurred at* 8:30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Summuell M. D.	Medical Arts Bldg	1/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 10, 1949	Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 8 - 1949	Huntington Williams, M.D.	Rita Weedefeld	900 E. Biddle St.

VS 150

92D

670312 420.0 ✓ 670312

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JOHN T. JACKSON — 2. DATE OF DEATH: 1/7/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General

C. Length of stay in Baltimore: ___ Yrs. ___ Mon. ___ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — D. STREET ADDRESS (If rural, give location): 935 N. Durham St. 7-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	M	[illegible]	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur — 10B. KIND OF BUSINESS OR INDUSTRY: J. A. Davis & Son

11. BIRTHPLACE (State or foreign country): Md. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Annie Cager

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): Yes - 1st W.W. — 16. SOCIAL SECURITY NO: 217-05-3901

17. INFORMANT: James E. Jackson — ADDRESS: 1201 Madison Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heart Failure

DUE TO

(B) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/6, 1949 *to* 1/7, 1949 *that I last saw the deceased alive on* 1/7, 1949 *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles J. Blazek Jr. M.D. — 23B. ADDRESS: Maryland General — 23C. DATE SIGNED: 1/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 1/11/49 — 24C. NAME OF CEMETERY OR CREMATORY: Balto. National — 24D. LOCATION (City, town, or county) (State): 5501 Frederick Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Joseph S. Locke Jr. — ADDRESS: 1304 N. Central Ave

VS 150

937

070313 — Dr. J.E.T. Camper ✓ — 070313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

HAY

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH SAMUEL DIGGS

2. DATE OF DEATH: Jan. 5, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 1712 N. Carey St.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1712 N. Carey St.

c. Length of stay in Baltimore: 71 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1712 N. Carey Street 15-1

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: May 1, 1877
9. AGE (In years last birthday): 71 — If under 1 Year: Months 8, Days 4; If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY: Bus hire
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Diggs
14. MOTHER'S MAIDEN NAME: Rosetta ?????

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Joseph Diggs Jr. ADDRESS: 1712 N. Carey St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio - Vascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: 16 mos
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1949 *to* Jan. 5, 1949 *that I last saw the deceased alive on* Jan 4, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: John E. T. Camper M. D.
23B. ADDRESS: 639 N. Carey St. Balto.
23C. DATE SIGNED: 1-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 8, 1949
24C. NAME OF CEMETERY OR CREMATORY: My. Zion
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1949
REGISTRAR'S SIGNATURE: Winifred for Williams
25. FUNERAL DIRECTOR: Mrs. George H. Hollam
ADDRESS: 1631 Druid Hill Ave

VS 150

131a

MARSheck.

G70314 — BALTIMORE CITY HEALTH DEPARTMENT — 157 — G70314

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Dassie B. Mar Sheck

2. DATE OF DEATH: 1/7/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — St. Agnes Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland — B. COUNTY: 1631 E-33rd St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1631 E. 33rd St. 9-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	—	4/30/1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	House wife	Maryland	

13. FATHER'S NAME: Charles Marshall

14. MOTHER'S MAIDEN NAME: Josephine Kirby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mr. R. Wilburt Mar Sheck	1631 E. 33rd St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardio-respiratory failure — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

(B) Carcinoma Head of Pancreas — DUE TO — 4 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Metastases to Liver

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/6/48	Carcinoma Head of Pancreas 1/6/48	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/26, 1948 *to* 1/7, 1949 *that I last saw the deceased alive on* 1/6, 1949, *and that death occurred at* 6:45 A.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Rafael V. Ramirez M. D.	St. Agnes Hospital	1/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 8, 1949	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 8 - 1949	[illegible] Baltimore, Md.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

468

70315 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

AX3 ✓ Registered No. G70315

1. NAME OF DECEASED (Type or Print): MARIE W. WARD

2. DATE OF DEATH: January 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 50 W. Biddle St. 11-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married	May 8, 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred W. Pue
14. MOTHER'S MAIDEN NAME: Katherine Watkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-01-2423
17. INFORMANT: Mr. John W. Pue ADDRESS: Fallston, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertensive cardiovascular disease	
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Koons M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/8/49
24C. NAME OF CEMETERY OR CREMATORY: St. John's Cem.
24D. LOCATION (City, town, or county) (State): Ellicott City, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, MD
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 151

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70516 V H10 G70516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Anna Dorothy Finnan**

2. DATE OF DEATH **Jan.6th., 1949**

3. PLACE OF DEATH: a. Baltimore City, Maryland **1312 Bonapart Aven**

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **None**

c. Length of stay in Baltimore **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **1312 Bonapart Avenue** B. COUNTY **Balto:Md.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore, City**

D. STREET ADDRESS (If rural, give location) **1312 Bonapart Avenue** 9-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Aug. 19, 1876	72	4	17	####	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	U.S.A.

13. FATHER'S NAME **Edward Goelhaar**

14. MOTHER'S MAIDEN NAME **Emma Wackes**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		None	Bernard J. Finnan	1312 Bonapart Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute Dilatation of Heart	15 min
DUE TO	Mitral Regurgitation Decompensated	5 d
ANTECEDENT CAUSES (B)	Arteriosclerosis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
(C)	Coronal Thrombosis with Cerebral Softening	3yr
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
Today		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 2, 1949, *to* Jan 6, 1949, *that I last saw the deceased alive on* Jan 6, 1949, *and that death occurred at* 4.35 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
I. S. A. Stevens M. D.	2878 Harford La	1-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/10/49	Baltimore Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 8 - 1949	Tunstin Stevenson, M.D.	George J. Ruth, Inc.	1735 Harford Avenue

VS 150

92 B

MEDICAL EXAMINER'S CASE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

70.17 (BIRTH NO.) — E900.0 N854.0 — 670.17 Registered No.

1. NAME OF DECEASED (Type or Print): MRS. ELIZABETH THOMAS
2. DATE OF DEATH: 1-6-49
3. PLACE OF DEATH: a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPH'S HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: MARYLAND; B. COUNTY: Baltimore; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE; D. STREET ADDRESS (If rural, give location): 73 Kinship Rd. Dundalk 22
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOW
8. DATE OF BIRTH: 1885
9. AGE (In years last birthday): 64 66 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HWFE.
10B. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Patrick McAntee
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: REGIS THOMAS — ADDRESS: 73 KINSHIP RD. DUNDALK

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SUB-DURAL HEMATOMA — INTERVAL BETWEEN ONSET AND DEATH: 12 days

DUE TO

(B) TRAUMA (FALL AT HOME) — 12 days

DUE TO

CERTIFICATION APPROVED BY

(C) [signature] M.D.
CHIEF OR ASST. MEDICAL EXAMINER

PNEUMONIA — 2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1-1-49 1-2-49 1-4-49
19B. MAJOR FINDINGS OF OPERATION: SUB-DURAL HEMATOMA
20. AUTOPSY? YES ☑ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE, (Specify): ACCIDENT
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): HOME
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 73 KINSHIP RD. DUNDALK 22
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 12 25 48 12 45 A.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR?: FALL DOWN STAIRS

22. *I hereby certify that I attended the deceased from* 12-30, 1948 *to* 1-6, 1949 *that I last saw the deceased alive on* 1-6, 1949 *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Joseph Krejci M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: 1-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: Jan. 10, 1948
24C. NAME OF CEMETERY OR CREMATORY: Scottdale
24D. LOCATION (City, town, or county) (State): Scottdale, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR — ADDRESS: Roland L. Fisher 2112 Dundalk Ave.

VS 150

186a

70318 ✓ 642.5 70318

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Valerie Lawson Palmer
2. DATE OF DEATH: 1/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1425 Madison ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1425 Madison Ave
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 1425 Madison
B. COUNTY: Balto Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md
D. STREET ADDRESS (If rural, give location): 1425 Madison Ave 14-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	married	10/28/26	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home Domestic	Domestic	Baltimore Md	U S A

13. FATHER'S NAME: William Lawson
14. MOTHER'S MAIDEN NAME: Mattie Wade

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT — ADDRESS
no	none		Mattie Lawson 1425 Madison Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Toxemia of Pregnancy — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
JAN 5/49 11 A M
JAN 6/49 1025 P.M

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JAN 5, 1949 *to* JAN 6, 1949 *that I last saw the deceased alive on* Jan 6, 1949 *and that death occurred at* 10:25 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr Lawson N. Rousee M. D.	1301 Penna Ave	Jan 6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	1/11/49	Hommany	South Boston Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 8 1949	Huntington Williams, M.D.	Wm A Jackson 916 Penna Ave

VS 150

144 D

G70319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#20.1 ✓

Registered No. G70319

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Martin Schweitzer

2. DATE OF DEATH: Jan. 6, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland — 204 S. Regester St.
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
a. COUNTY: 204 S. Regester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
d. STREET ADDRESS (If rural, give location): 204 S. Regester St. 2-2

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 11, 79
9. AGE (In years last birthday): 69 70 — If Under 1 Year: Months: 5, Days: 25 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: City
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Schweitzer
14. MOTHER'S MAIDEN NAME: Elizebeth Henss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Mrs. E. Schweitzer, 204 S. Regester

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral hemorrhage	5 hrs.
	DUE TO Arterial Sclerosis	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Myocarditis. Coronary occlusion.	
	DUE TO Arteriosclerosis	5 yrs
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Gastroptosis	5 yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 21, 1948 *, to* Jan. 6, *, 19* 49 *that I last saw the deceased alive on* Jan. 3 *, 1949 , and that death occurred at* 9:30A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Albert G. Bingwald M. D.
23B. ADDRESS: 1613 E. North Ave.
23C. DATE SIGNED: 1-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 10, 49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: L. Heemann and Son 6067 Harford Rd.

VS 150

93D

ORVAL CANTER

70320 BALTIMORE CITY HEALTH DEPARTMENT 416 ✓ G70320

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Orval Canter

2. DATE OF DEATH: 1-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp. Balto Md
C. Length of stay in Baltimore: 8 years. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN, (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 914 W. Baltimore St. 18-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male.	White	Married.	July-14-1919.	29 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist?
10B. KIND OF BUSINESS OR INDUSTRY: Beth. Shipyards.
11. BIRTHPLACE (State or foreign country): Portsmouth - Ohio
12. CITIZEN OF WHAT COUNTRY? —
13. FATHER'S NAME: Warren Canter.
14. MOTHER'S MAIDEN NAME: Flora Demint.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Ada B. Canter. ADDRESS: 914 W. Balto. St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) (Rheumatic C-V-) disease
DUE TO
(B) Subacute bacterial Endocarditis +
DUE TO
(C) secondary lung abst)ess

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: None
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): None
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: None m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? None

22. *I hereby certify that I attended the deceased from* 1-4 19 49 *to* 1-7, 19 49, *that I last saw the deceased alive on* 1-7-49 19 , *and that death occurred at* 3 30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: University Hosp Balto Md
23C. DATE SIGNED: 1-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal - Jan. 9. 1949.
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Coreys Run Cemetery.
24D. LOCATION (City, town, or county) (State): Portsmouth - Ohio.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1949
REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: Charles J. Schwab. ADDRESS: 3512 Frederick Ave.

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0321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E903.0 H821.0 G70321

Registered No. 369 8.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1131 W. Franklin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
18-2
(d) Street No. 1131 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Elizabeth Williams

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	married

6 (b) Name of husband or wife Wesley Williams
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr) Sept 1 1897

8. AGE: Years	Months	Days	If less than one day
51	4	5	hr. min.

9. Birthplace Gloucester Co. Va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Home Work

FATHER
12. Name Wm. Thomas West
13. Birthplace Va

MOTHER
14. Maiden Name Martha Curtis
15. Birthplace Va

16 (a) Informant Mrs Lolan Earl Armstrong
(b) Address 933 Saratoga

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 8, 1949 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JAN 8 - 1949 (Date rec'd by registrar) (b) Lexington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6- 1949 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1948 to 1-6- 1949 and that I last saw her alive on 1-5 1949.

	Duration
Immediate cause of death Carcinomatosis	10 mo
Due to Carcinoma of cervix	unknown
Due to	
Other Conditions Fracture of left femur	3 mo

(Include pregnancy within 3 months of death)

Date of operation CERTIFICATION APPROVED BY
Major findings of operation:
G. G. Merrill
of autopsy: CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence October 28, 1948 at ? M
(c) Where did injury occur? 1131 W. Franklin St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury slipped on steps

23. Signature Frank A. Saunders M.D.
Address 1029 N. Stricker Date signed 1-6-49

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186a

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

470.0 ✓ Registered No. G70322

~~G~~70322
BIRTH NO.

1. NAME OF DECEASED (Type or Print) LILLIA SMITH

2. DATE OF DEATH January 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 311 N. Gilmor St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 311 N. Gilmor St..
C. Length of stay in Baltimore 53 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 311 N. Gilmor St. 19-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Single	January 1, 1896.	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife.		Maryland	U.S.A.

13. FATHER'S NAME Unknown.

14. MOTHER'S MAIDEN NAME Deborah Smith.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Felix Gaither.	1002 N. Calhoun St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic cardiovascular disease.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George L. Merrill M.D.		1-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-8-1949.	Mt. Auburn	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 8 - 1949	Huntington Williams, M.D.	Mrs Katie R. Williams	322 N. Schroeder St

VS 151

93D

G70323 ✓ 176 G70323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C. 49-00153

1. NAME OF DECEASED (Type or Print): Baby Girl Diegert

2. DATE OF DEATH: January 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

C. Length of stay in Baltimore: 1 day (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Joppa, Md.
D. STREET ADDRESS (If rural, give location): Mt. Road, Joppa, Maryland

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Jan. 7, 1949			1	3	35

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Maryland	

13. FATHER'S NAME: Raymond Phillip Diegert

14. MOTHER'S MAIDEN NAME: Margaret Lorraine Zealer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 7 *, 1949, to* Jan. 8 *, 1949, that I last saw the deceased alive on* Jan. 8 *, 1949, and that death occurred at* 8:00 AM *, from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Daniel Ehrlich M. D.	St. Joseph Hosp.	1/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/1/49	Midland	Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 8 - 1949	Huntington Williams, M.D.	Lassahn Funeral Home	1401 Aisquith

VS 150

159

670324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H20.0

Registered No. 670324

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRY W. HEYN

2. DATE OF DEATH Jan. 6th, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 3010 Federal St.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 3010 Federal St. E-2

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower

8. DATE OF BIRTH Nov. 2nd, 1857

9. AGE (In years last birthday) 91 — If Under 1 Year: Months 2, Days 4; If Under 24 Hours: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY Farmer

11. BIRTHPLACE (State or foreign country) Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. J. Allen Erman, Sr. ADDRESS 3010 E. Federal St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio Sclerotic Heart Disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH: ?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/27 1948 *to* 1/6/49, 19__, *that I last saw the deceased alive on* 1/6/49, 19__, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE Max Baum, M. D.

23b. ADDRESS 1501 N. Milton Ave.

23c. DATE SIGNED 1/7/49

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE 1/10/49

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State) New Freedom, Pa.

DATE RECEIVED BY LOCAL REGISTRAR JAN 8 - 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Lansdale Funeral Home ADDRESS 7401 Belair Rd.

VS 150

9-D

70325 BALTIMORE CITY HEALTH DEPARTMENT 571.0 G70325

CERTIFICATE OF DEATH

BIRTH NO. B.C. 48-20421 Registered No.

1. NAME OF DECEASED (Type or Print): Leydic, Marilyn Lee
2. DATE OF DEATH: 1/8/49
3. PLACE OF DEATH: a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY Balto City C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md. D. STREET ADDRESS (If rural, give location): 2826 Chesterfield Rd. 27-20
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept, 1948
9. AGE (In years last birthday): If Under 1 Year: Months 4, Days -; If Under 24 Hours: Hours -, Min. -
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant
10B. KIND OF BUSINESS OR INDUSTRY: infant
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: George D. Leydic
14. MOTHER'S MAIDEN NAME: Lillian Wallace
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no / no
16. SOCIAL SECURITY NO.
17. INFORMANT: Lillian W Leydic ADDRESS: Dorsea pt.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respirations ceased
DUE TO Dehydration, acidosis, shock
Or Calcium depletion
INTERVAL BETWEEN ONSET AND DEATH: few minutes

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO Diarrhea — 10 hrs 25 mins
(C) DUE TO viral infection probably — > 10 hrs 25 mins

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~10~~ *to* ~~19~~, *that I last saw the deceased alive on* 1/7, 19 49 *and that death occurred at* 2.40A m. *from the causes and on the date stated above.*

23A. SIGNATURE: J.R. Hankins, M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ellwood L Comacent ADDRESS: 3911 Lib Hyde Park

VS 150

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G70326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 480 G70326

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anna McConville

2. DATE OF DEATH 1-7-49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2411 E. Preston St 8-3

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH 4-22-1880 | 9. AGE (In years last birthday) 68 | If Under 1 Year: Months 9 Days 3 | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | 10B. KIND OF BUSINESS OR INDUSTRY Steward's | 11. BIRTHPLACE (State or foreign country) Balto Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph McConville | 14. MOTHER'S MAIDEN NAME Theresa D. Frank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO 216-09-7345 | 17. INFORMANT Pete Williams ADDRESS 2021 Ellamont St

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Superior Mesenteric Thrombosis	
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Hypertensive, Arteriosclerotic C-V Disease & Auricular Fibrillation	
	DUE TO	
	(C) General Arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-5, 19 49 *to* 1-7, 19 49 *that I last saw the deceased alive on* 1-7, 19 49 *and that death occurred at* 1030 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE John A. Hufstader M. D. | 23B. ADDRESS University Hospital | 23C. DATE SIGNED 1-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Jan 10 49 | 24C. NAME OF CEMETERY OR CREMATORY Parkwood | 24D. LOCATION (City, town, or county) (State) Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR JAN 8 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR John C. Miller, Inc. | ADDRESS 2435 Oliver

VS 150

93D

G70327 — BALTIMORE CITY HEALTH DEPARTMENT — G70327

CERTIFICATE OF DEATH

391 ✓ Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WALTER ZMIJEWSKI

2. DATE OF DEATH: 07 JAN 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2701 4618 CROSSWOOD AVE #14

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 07 AUG 1912
9. AGE (In years last birthday): 36 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSPECTOR
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: AMERICA

13. FATHER'S NAME: John Zmijewski
14. MOTHER'S MAIDEN NAME: Stefania Dobrzycha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: HELEN ZMIJEWSKI — ADDRESS: SAME AS DECEASED

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 29 Days
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☒ Refused

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): NONE
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 13 DEC 1948 *to* 7 JAN 1949 *that I last saw the deceased alive on* 7 JAN 1949, *and that death occurred at* 3:38 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: Donald F. England M. D.
23B. ADDRESS: Maryland Gen. Hosp.
23C. DATE SIGNED: 7 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 11 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cem.
24D. LOCATION (City, town, or county) (State): Balto County

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR — ADDRESS: Mrs Mary Weber 832

VS 150

G70328 BALTIMORE CITY HEALTH DEPARTMENT G70328

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Annie E Brown
2. DATE OF DEATH: Jan 9-1949
3. PLACE OF DEATH: a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp
c. Length of stay in Baltimore: 15 yrs (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3414 Hickory Ave 12-6
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: July 25 1869
9. AGE (In years last birthday): 79 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Hanover, Pa.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Silas Miller
14. MOTHER'S MAIDEN NAME: Elizabeth ---
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)
16. SOCIAL SECURITY NO. --
17. INFORMANT: Mrs Florence B. Sibert ADDRESS: 3414 Hickory Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) A.S.C.V.D. — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Ed L Ruge M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED: 1-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 1/11/49 | 24C. NAME OF CEMETERY OR CREMATORY: New Oxford | 24D. LOCATION (City, town, or County) (State): Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Rd

VS 151

937

G70329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

571.0

G70329 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 Bridgeview Road.
(c) Hospital or institution: Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Weeks
(e) Length of stay in Baltimore (yrs., mos., or days) 8 weeks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore 25 Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Bridgeview Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Estwick

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16, 1948

8. AGE: Years	Months	Days	If less than one day
	2	23	— hr. — min.

9. Birthplace New York, N Y (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Bertram Estwick
13. Birthplace New York, N.Y.

MOTHER
14. Maiden Name Peggy D. Estwick
15. Birthplace Newport News, VA.

16 (a) Informant Peggy Estwick
(b) Address 518 Bridgeview Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/49 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles R. Law
(b) Address 502 Madison Ave

JAN 9 1949 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-8 1949 at 10:15 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1948 to 1-8-1949. and that I last saw him alive on 1-2 1949.

Immediate cause of death Toxic Diarrhea — Duration

Due to Dehydration.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Jerry L. Fleck

Address 303 Bridgeview Date signed 1/8/49 M. D.

VS 150

Courtesy Worthington Williams, M.D.

1190

G70530 G70530

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Eugenia Parker

2. DATE OF DEATH: Jan. 7, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland — Baltimore, Md.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2031 W. Lanvale Street

c. Length of stay in Baltimore: 22 Yrs. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN. (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2031 W. Lanvale Street 16-4

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Separated
8. DATE OF BIRTH: April 1900
9. AGE (In years last birthday): 48 — If Under 1 Year: Months 9, Days 2; If Under 24 Hours: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Norfolk, Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Louis Sparrow
14. MOTHER'S MAIDEN NAME: Catherine Sparrow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Martha Parker--2031 W.Lanvale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral embolism — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Cancer of uterus — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION: 8-4-48
19b. MAJOR FINDINGS OF OPERATION: Laceration Lacerated & fibromyoma uteri
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1948, to 1-7, 1949, *that I last saw the deceased alive on* 1-7 1949 *and that death occurred at* 1-10 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE: Stanford R Innerarity M. D.
23b. ADDRESS: 2309 Druid Hill
23c. DATE SIGNED: 1-8-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/11/49
24c. NAME OF CEMETERY OR CREMATORY: Calvary Cem.
24d. LOCATION (City, town, or county) (State): Norfolk, Virginia

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Charles R. Law- 802 Madison Ave.

VS 150

48B

G70531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#43 G70531 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ZELDA RICHMOND

2. DATE OF DEATH: 1-8-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3906 Norfolk Ave

Length of stay in Baltimore: 74 Yrs. Mths. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-9
D. STREET ADDRESS (If rural, give location): 3906 Norfolk Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1882
9. AGE (In years last birthday): 67
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph
14. MOTHER'S MAIDEN NAME: Not Known

15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Lewis E Levine - ADDRESS: 3706 Norfolk Ave

CAUSE OF DEATH

18.

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Failure
DUE TO
(B) Ch Myocarditis
DUE TO
(C) Ch Hypertention

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/2/49 *to* 1/6/49 *that I last saw the deceased alive on* 1/7/1949 *and that death occurred at* 9:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Jos Hornstein M. D.
23B. ADDRESS: 204 E. Biddle St
23C. DATE SIGNED: 1/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-49
24C. NAME OF CEMETERY OR CREMATORY: Beth Tefiloh
24D. LOCATION (City, town, or county) (State): Woodsdale Mill Road

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis
ADDRESS: 2100 Eastern Ave

VS 150

937

G70532 ✓ 420.0 G70532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Phoebe E. Johnson

2. DATE OF DEATH Jan. 8th 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 2516 Talbot Road
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 9 Mo (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2516 Talbot Rd. 28-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Nov. 2 1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Wisconsin	

13. FATHER'S NAME: George Higgs

14. MOTHER'S MAIDEN NAME: Sarah Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Mrs. Karl Ehrgott 2516 Talbot Rd

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic Cardio-Vascular Disease.	?
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C) Bronchiectasis - Senility.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1948, *to* Jan. 8, 1949 *that I last saw the deceased alive on* 1/8, 1949, *and that death occurred at* 5:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald Clay MacLaughlin M. D.	400 N. Payson St.	1/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Jan. 9 1949	St. Stephans Lutheran	New Lisbon Wisconsin

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 9 1949	Huntington Williams, M.D.	William J. Tickner & Sons North & Pa Av.

VS 150

93D

G70333 — BALTIMORE CITY HEALTH DEPARTMENT — G70333 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 E. North Ave
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 E. North Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** CHRISTINA BALONIS

3 (b) If veteran, name war none | 3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 - 1878

8. AGE: Years 71 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Russia (City, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER — 12. Name Jacob Balonis — 13. Birthplace Russia

MOTHER — 14. Maiden Name Unknown — 15. Birthplace Unknown

16 (a) Informant John Bayliss (b) Address Hillsmere Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-49 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Location Mt Carmel Pa.

18 (a) Funeral director Charles W Faehnrich (b) Address 203 N E Kenny St.

JAN 10 1949 (Date rec'd by registrar) (b) Huntington Williamsport Pa

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-8 1949 at 11.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1943 to 1-8 1949 and that I last saw h alive on 1-8 1949

Immediate cause of death: Acute Cardiac Failure — Duration 1 da

Due to: Cardiovascular Renal — 5 yr

Due to: Disease — 5 yr

Other Conditions: Hospitalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph E Lankas M. D.

Address 6 W Washington Blvd Date signed 1/9/49

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G70534 ✓ 757.3 154.1 G70534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 48-9028 Registered No.

1. NAME OF DECEASED (Type or Print) Baby Girl Ditzel

2. DATE OF DEATH Jan 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.

C. Length of stay in Baltimore Yrs. 2 Mos. months 16 Days days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Joppa Road - Riderwood
D. STREET ADDRESS (If rural, give location)

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Babe

8. DATE OF BIRTH October 23 1948 | 9. AGE (In years last birthday) — | If Under 1 Year: Months 2 Days 16 | If Under 24 Hours: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Babe

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John R Ditzel

14. MOTHER'S MAIDEN NAME Blanche Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (If no, or unknown)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS Hospital Records - Union Memorial

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Congintal deformities Prematurity — INTERVAL BETWEEN ONSET AND DEATH: Since birth

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) a) Horse shoe Kidney b) Inter ventricular Septal Defect and patent Ductus arteriosis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 4, 1948, *to* Jan. 8, 1949, *that I last saw the deceased alive on* Jan. 7, 1949, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23A. SIGNATURE R. Donald Emery M. D. | 23B. ADDRESS 3301 St. Paul St. | 23C. DATE SIGNED 1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1/9/1949 | 24C. NAME OF CEMETERY OR CREMATORY Sater's Baptist Cem. | 24D. LOCATION (City, town, or county) (State) Lutherville, Balto. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 9 1949 | REGISTRAR'S SIGNATURE Carrington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS JOHN BURNS' SONS — TOWSON, MD.

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G70335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 Registered No.

G70335

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joe Grahomya

2. DATE OF DEATH: JAN 9 - 1949

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

3b. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W. Va.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lillybrook
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 3-10-87
9. AGE (In years last birthday): 61
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Grahomya
14. MOTHER'S MAIDEN NAME: Rose Mikla

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Lung
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: ± 6 mos.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Pulmonary Edema + Cardiac Failure

19A. DATE OF OPERATION: Dec 15, 1948
19B. MAJOR FINDINGS OF OPERATION: Inoperable Carcinoma Lung
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-10-1948 *to* 1-9-1949, *that I last saw the deceased alive on* 1-9-1949 *and that death occurred at* 3 50 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dalooley M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: 1-9-49
24C. NAME OF CEMETERY OR CREMATORY: BECKLEY-W. VA
24D. LOCATION (City, town, or county) (State): BECKLEY, W. VA.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: WM. COOK INC.
ADDRESS: 1219 ST PAUL.

VS 150

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AB-118586
G70336

BALTIMORE CITY HEALTH DEPARTMENT 443
CERTIFICATE OF DEATH
Registered No. G70336

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary O'Donnell
2. DATE OF DEATH: 1-9-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1510 Henry St. 24-4

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 18- 1865
9. AGE (In years last birthday): 83 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Henry Smith
14. MOTHER'S MAIDEN NAME: Christina E. Rhoades

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Records-Baltimore City Hospitals, 4940 Eastern Ave.

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary edema	1-2 hours.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Hypertensive-Cardiovascular disease	Years
	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Bronchopneumonia	1 day

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 1, 1948 *to* Jan. 9, 1949 *that I last saw the deceased alive on* Jan. 9, 1949 *and that death occurred at* 5:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. Stutzman, M. D.
23B. ADDRESS: Balto. City Hosp.
23C. DATE SIGNED: Jan. 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-11-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
24D. LOCATION (City, town, or county) (State): Frederick - Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. E. Cline & Son
ADDRESS: Fred'k. - Md.

VS 150

937

G70337 ✓ 332 G70337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MRS. AMELIA BELLOFF
2. DATE OF DEATH: 07 JAN 49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 25-42
D. STREET ADDRESS (If rural, give location): 1636 SPENCE ST. #30
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 22 OCT 1884
9. AGE (In years last birthday): 64
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: SON CAROL O. BELLOFF
ADDRESS: SAME AS DECEASED

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY

DUE TO

(B) CEREBRAL ARTERIOSCLEROSIS — FEW YEARS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NO
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): NONE
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 30 PM 7 JAN, 1949, *to* 8 15 PM 07 JAN 1949 *that I last saw the deceased alive on* 07 JAN, 1949, *and that death occurred at* 8 15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Donald L. England M. D.
23B. ADDRESS: Maryland Gen. Hosp.
23C. DATE SIGNED: 07 JAN 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-10-49
24C. NAME OF CEMETERY OR CREMATORY: St Pauls Cem.
24D. LOCATION (City, town, or county) (State): Violetsville Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25 FUNERAL DIRECTOR: Mrs Chas A Rohde
ADDRESS: 2327 Edmondson Ave

VS 150

83 B

70338 ✓ 260 G70338

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) AGNES MORAN

2. DATE OF DEATH JAN-7-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE Co.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) GOOD SAMARITAN Hosp. 27 N CAREY ST.

C. Length of stay in Baltimore LIFE TIME Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 2115 BARKLEY ST
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2115 BARKLEY ST. 12-4

5. SEX FEM

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOW

8. DATE OF BIRTH JAN 20 1881

9. AGE (In years last birthday) 67 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK AT HOME

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME JOSEPH. RAKERS

14. MOTHER'S MAIDEN NAME ROSE J. McABEE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT ADDRESS MRS REGINA STIFLER-317 E. 23rd ST.

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myocarditis	2 weeks
	DUE TO	
ANTECEDENT CAUSES	(B) Chronic Nephritis	Unknown
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C) Diabetes Mellitus	Unknown
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 18 '48 *to* 1/7/49, 19__, *that I last saw the deceased alive on* 1/6/49, 19__, *and that death occurred at* 2:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Walter J Donn M. D.

23B. ADDRESS 4012 Edmondson

23C. DATE SIGNED 1/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1-11-49

24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem

24D. LOCATION (City, town, or county) Woodlawn Md (State)

DATE RECEIVED BY LOCAL REGISTRAR JAN 10 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Bernard C Harlo ADDRESS 121 E West St

VS 150

61

G70339 ✓ 334 G70339

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ALBERT H. BRETALL

2. DATE OF DEATH: JAN 9th 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 735 W HAMBURG ST

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore LIFE TIME (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 735 W HAMBURG ST
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE MD
D. STREET ADDRESS (If rural, give location) 735 W HAMBURG ST 21-1

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: AUG 10 1889
9. AGE (In years last birthday): 59 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SHIPPING CLERK
10B. KIND OF BUSINESS OR INDUSTRY: PIPE FITTING
11. BIRTHPLACE (State or foreign country): BALTIMORE MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: NOT KNOWN
14. MOTHER'S MAIDEN NAME: NOT KNOWN.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO. 218-01-2452
17. INFORMANT: BESSIE BRETALL ADDRESS 735 W HAMBURG ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia Apoplectic — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Hypostatic congestion
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1/12 19 44 to 1/9 19 49 that I last saw the deceased alive on 1/9 19 49 and that death occurred at 1:30 P.M. from the cause and on the date stated above.

23A. SIGNATURE Dr. Sudler M. D.
23B. ADDRESS 3323 E. Baltimore St
23C. DATE SIGNED 1/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE 1-12-49
24C. NAME OF CEMETERY OR CREMATORY: HOLY CROSS CEMETERY
24D. LOCATION (City, town, or county) (State): A. A. Co.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Bernard C. Hurle ADDRESS 1211 E. West St

VS 150 DR SUDLER - 3323 E BALTO ST ORLEANS 7397 83a

G70340 ✓ 420.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70340

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph J. Pye
2. DATE OF DEATH: 1/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3706 N Charles St 20-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	July 28 1892	56	5	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Marine Engineer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: [illegible] Pye
14. MOTHER'S MAIDEN NAME: Henrietta Jordan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Ida J. Pye ADDRESS: 3706 N Charles St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Vascular Disease	
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Inspection or Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: John R Deers M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/49
24C. NAME OF CEMETERY OR CREMATORY: Mouland Park
24D. LOCATION (City, town, or county) (State): Baltimore Co- Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilhorn & Son Inc.
ADDRESS: 1219 Druid Hill Ave

VS 151

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70341

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1 G70341

Registered No.

1. NAME OF DECEASED (Type or Print): John F. Cooper

2. DATE OF DEATH: Jan 7th 1948 (1949)

3. PLACE OF DEATH: a. Baltimore City, Maryland 1718 E. 30th St.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1718 E. 30th St. 9-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Sept. 15th 1890	58 57	3	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10B. KIND OF BUSINESS OR INDUSTRY: American Hammer Piston Ring Co

11. BIRTHPLACE (State or foreign country): Balto. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Stephens Cooper

14. MOTHER'S MAIDEN NAME: Kate Gruner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-09-8521

17. INFORMANT: John T. Cooper ADDRESS: 8733 Old Harford Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 8 months

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr, 1948, to Jan, 1949, that I last saw the deceased alive on Jan. 3, 1949, and that death occurred at 1:15 A. m., from the causes and on the date stated above.

23A. SIGNATURE: Roy M. Zimmerman M. D.

23B. ADDRESS: 2854 Harford Rd.

23C. DATE SIGNED: 8 Jan. 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/10/49

24C. NAME OF CEMETERY OR CREMATORY: London Park

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. Cook Inc. ADDRESS: 1217 St. Paul st. Balto. Md.

VS 150

94a

70342
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70342

1. NAME OF DECEASED (Type or Print) Beulah Keefer
2. DATE OF DEATH January 8, 1949
3. PLACE OF DEATH: a. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
d. Length of stay in Baltimore 59 Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location) 2617 East Preston St. E-3
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH 12-29-89
9. AGE (In years last birthday) 59 If Under 1 Year: Months 0 Days 9 If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John W. Keefer
14. MOTHER'S MAIDEN NAME Mary Hubbard.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Myocardial Infarction	5 minutes
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Central nervous system syphilis	

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES X NO
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-3 1949 *to* 1-8 1949 *that I last saw the deceased alive on* 1-8 1949, *and that death occurred at* 9 35 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE John S. Whitmer M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 1/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/12/49
24C. NAME OF CEMETERY OR CREMATORY Western
24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 10 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wilhom Co Inc
ADDRESS 1214 Edmondson Ave

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B.C. 48-208705 ✓ 161c

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 70343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7609 North Point Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Snyder (469845)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 30-48

8. AGE: Years	Months	Days	If less than one day
			hr. 40 min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Snyder
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Theresa Van Meter
15. Birthplace West Virginia

16 (a) Informant The Johns Hopkins Hospital
(b) Address 601 North Broadway

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) JAN 10 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 19 48 at 1:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30-48 19 to 12-31 19 48 and that I last saw him alive on 12-31 19 48

Immediate cause of death	Anoxia	
Due to	cause, unknown	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Anoxia

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glen C. Rice, M.D.
Address The Johns Hopkins Hospital Date signed 1-5-49

VS 150

44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G70,344 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 128 N. Calvin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jacobs, James Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Laura Jacobs ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
40 ?			hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory University Medical School DEC 22 1948
Location Commissioner of Health
18 (a) Funeral director
(b) Address
19 (a) JAN 10 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948, at 12:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/16/ 1948 to 11/20/ 1948 and that I last saw him alive on 11/20/ 1948.

Immediate cause of death Subarachnoid Hemorrhage

Due to Hypertension

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Provident Hosp Date signed 12-22-48

VS 189

B.C. 48-2709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 Registered No. G70345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Bedwood & Greene St.
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? No. — (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male.	Negro.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec - 12 1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace University Hospital. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name James Williams
13. Birthplace Ellicott City Maryland.

MOTHER
14. Maiden Name Sadie Louise Rayles.
15. Birthplace (Unknown) Pennsylvania.

16 (a) Informant Mother. Sadie Williams
(b) Address 807 Penn. Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location University Medical School DEC 22 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 10 1949 (Date rec'd by registrar) (b) Remington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1948, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1948 to Dec 14 1948 and that ~~I last saw~~ he/she was alive on Dec. 12 1948.

Immediate cause of death Asphyxia — Duration

Due to Prolapse Expiration of cord

Due to Prematurity Birthwt. 11b 7 ozs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Patterson Wade M. D.
Address Univ. Hospital Date signed 12-21-48

VS 150

46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183 Registered No. 670.46

1. PLACE OF DEATH: Warner Street & Alluvion Street
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 747 Ryan Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CARRIE DRIDDEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

MOTHER / FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name unknown

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School DEC 20 1948 Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) JAN 10 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1948, at 11:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident or suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Found: 12-6-48 at 11:45 A. M.

(b) Where did injury occur? Found: Warner & Alluvion Sts.

(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? No

(d) Means of injury Found drowned

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 12/6/48

VS 121

70.47 ✓ 420.1 443 G70.47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John E. Warthen Sr

2. DATE OF DEATH: Jan 8-1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Towson

c. Length of stay in Baltimore: ? Yrs. Mos. Days

d. STREET ADDRESS (If rural, give location): 604 North Bend Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M.	W.	M.	5-1-1876	72 73	8	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plasterer	Retired	Emmittsburg Md	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Henrietta Warthen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: 216-01-1049

17. INFORMANT ADDRESS

CAUSE OF DEATH

18.

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Myocardial Infarcts — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic hypertensive CVD — ? yrs.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
None		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/7, 1949 *to* 1/8, 1949 *that I last saw the deceased alive on* 1/8, 1949, *and that death occurred at* 11:30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert J. Luckas M. D.	St. Agnes Hospital	1/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 12. 1949	New Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 10 1949	Huntington Williams, M.D.	M. Mrs. John R. Trefz & Son	5311 Edmondson Ave

VS 150

937

483/35

70348

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X578 (1) 70X

Registered No. 70348

1. NAME OF DECEASED (Type or Print): Dixon Ossie Sides

2. DATE OF DEATH: JAN 10 1949

3. PLACE OF DEATH: Baltimore City, Maryland Balto - City -

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE: N. C.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): GASTONIA,
D. STREET ADDRESS (If rural, give location): R.F.D. # 2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	White	married	3-2-89	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Dixon
14. MOTHER'S MAIDEN NAME: LAVINA JENKINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pneumonia	4 & hrs.
DUE TO (B)	Fecal fistula and fluid loss	2 wks.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Post-operative wound disruption (Operation)	2 wks.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Obesity - Probably diverticulitis of colon	

19A. DATE OF OPERATION: 12/11/48
19B. MAJOR FINDINGS OF OPERATION: Colostomy - Mass in rt. pelvis - Adhesions
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-5- 1948 *to* 1-10- 1949 *that I last saw the deceased alive on* 1-10- 1949 *and that death occurred at* 12.45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Milton Edenton M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1-10-49
24C. NAME OF CEMETERY OR CREMATORY: Gastonia N.C.
24D. LOCATION (City, town, or county) (State): Brothers-Funeral-Home Gastonia - N.C.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ray B. Wolverton Inc.
ADDRESS: 403-E-25th ST.

VS 150

123

70349 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G70349

B.C.48-27582 **CERTIFICATE OF DEATH** 157E

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 E. Jefferson St. Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Baby Crocker.

If U. S. Veteran specify WAR .....

(a) Residence: No. 1311 E. Jefferson St., 5th Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) 22 Dec 48

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

FATHER

13. NAME Alexander Crocker.

14. BIRTHPLACE (city or town) (State or country) Balto Md.

MOTHER

15. MAIDEN NAME Julia Brewer

16. BIRTHPLACE (city or town) (State or country) Newport News Va.

17. INFORMANT Alexander Crocker

(Address) 1311 E. Jefferson.

18. BURIAL, CREMATION, OR REMOVAL

Place [redacted] DEC 29 1948 19

19. UNDERTAKER Commissioner of Health

(Address)

20. FILED JAN 10 1949 19 Hamilton Williams, M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 23 Dec, 19 48

22. I HEREBY CERTIFY, That I attended deceased from 22 Dec 19 48 to 23 Dec 19 48

I last saw him alive on 23 Dec 19 48 Death is said to have occurred on the date stated above, at 10 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Patent ductus arteriosus	
Other contributory causes of importance:	

Was an operation performed? No Date of .....

For what disease or injury? —

Name of operation .....

What test confirmed diagnosis? — Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19 ....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

..... If so, specify .....

(Signed) A. C. Burwell M. D.

(Address) (2) Aisquith St.

X

0350

BALTIMORE CITY HEALTH DEPARTMENT ✓ 1318 Registered No. 670350

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
3-2
(d) Street No. 22 S. High St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN GREENWALD

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 29 1948 Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) JAN 10 1949 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1948, at 7 P.M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic nephritis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royster M.D. Medical Examiner.
Date signed 12/21/48

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0-51

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 670-51

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location) UNKNOWN
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE BLEDSOE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace UNKNOWN

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 29 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 10 1949 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1948, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH Diabetic Mellitus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner M.D.

Date signed 12-19-48

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B.C. 48-23826 157 E 670 52 Registered No. 52

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janet Barnett

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-26-47

8. AGE: Years	Months	Days	If less than one day
	1		hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name James Miller
13. Birthplace Fla.

MOTHER
14. Maiden Name Lennie Bennett
15. Birthplace Md.

16 (a) Informant Mother
(b) Address 721 Harlem Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 23 1948

18 (a) Funeral director Commissioner of Health
(b) Address Huntington Williams, M.D.

19 JAN 10 1949 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1948, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1948 to 12/18 1948 and that I last saw him alive on 12/18 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Congenital Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Dallas M. D.
Address Union Mem. Hosp. Date signed 12/18/48

VS 150

X

G70-53 ✓ 763.0 G70-53

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.49-00472 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Feld

2. DATE OF DEATH: Jan 9, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai

c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-H
d. STREET ADDRESS (If rural, give location): 4042 Cedardale Road

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1-6-49
9. AGE (In years last birthday): If under 1 Year: Months / Days: 3; If under 24 Hours: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Herman Feld
14. MOTHER'S MAIDEN NAME: Hetta Horwitz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Herman Feld ADDRESS: 4042 Cedardale Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory failure
DUE TO
(B) Pneumonia (L. L. lobe)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 6 1949 *to* Jan 9, 19 49 *that I last saw the deceased alive on* Jan 9 1949, *and that death occurred at* 5 25 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: David Josephson M.D.
23b. ADDRESS: Sinai Hosp
23c. DATE SIGNED: Jan 9 1949

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-10-49
24c. NAME OF CEMETERY OR CREMATORY: Rosedale
24d. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

✓ 10 A

G70354 ✓330 G70354

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Frank H Heyer

2. DATE OF DEATH: 1-8-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. 15-10
D. STREET ADDRESS (If rural, give location): 4019 Dorchester Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W		1-20-1884	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Mgr		Md	

13. FATHER'S NAME: Francis

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		wife	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO

(B) Arteriosclerotic Vascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-31-48, 19 49, *to* 1-8-, 19 49, *that I last saw the deceased alive on* 1-8, 19 49, *and that death occurred at* 7 45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
G. J. Laham M. D.	Franklin Sq Hosp.	1-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/12/49	Cathedral	Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 10 1949	Lurington Williams, MD	J. J. Fahey & Sons	937

VS 150

G70355 ✓776 G70355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-00227 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Stewart

2. DATE OF DEATH: Jan 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 338 S. Fulton Ave. 19-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	Jan 7, 1949			6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: J. Robert Stewart
14. MOTHER'S MAIDEN NAME: Veronine Yarnega

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: J. R. Stewart ADDRESS: 338 S. Fulton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 7, 1949 *to* Jan 7, 1949, *that I last saw the deceased alive on* Jan 7, 1949, *and that death occurred at* 2 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE: David Josephs, M.D. M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: Jan 9-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. J. Tokeyton Sons
ADDRESS: 1318 Light

VS 150

159

70356 BALTIMORE CITY HEALTH DEPARTMENT 153 G70356
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Cora Wilkerson - (W. Wilkinson) 2. DATE OF DEATH 1/8/49 12 05 AM

3. PLACE OF DEATH: Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4003 Gov. Ritchie Highway.

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

3b. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married.	May 24	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md.	

13. FATHER'S NAME Jay Buren Anderson
14. MOTHER'S MAIDEN NAME Jerusha Spears

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, Lobar Left Lower, Hypostatic Rt Lower.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Intestinal Obstruction from Rectal (Sigmoid) Malignancy

DUE TO (C) Aplastic Anemia

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis Generalized

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 | 4, 19 49 *to* 1 | 7, 19 49, *that I last saw the deceased alive on* 1/7/49 19, *and that death occurred at* 12 05 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	SBGH	1/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B.	1-10-49	Cedar Hill	Brooklyn.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 10 1949	Huntington Williams, M.D.	James L. McCully	130 S. Fort Ave.

VS 150

46E

70357 252.0 ✓ 422.2 G70357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): FRANK L. BRENDEL

2. DATE OF DEATH: 1/7/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1235 Battery Avenue

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1235 Battery Avenue 24-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	S	3/2/1886	62	10	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Oil Station

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis H. Brendel

14. MOTHER'S MAIDEN NAME: Annie E. Buckman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Family - 1235 Battery Avenue ADDRESS

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic Myocardial Degeneration	2 yr.
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Thyrotoxicosis	3 yr.
	DUE TO	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-3, 1949, *to* 1-7, 1949, *that I last saw the deceased alive on* 1-7, 1949, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	707 E. Fort Ave.	1-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	1/11/49	Loudon Park	3801 Frederick Avenue

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 10 1949	Huntington Williams, M.D.	James L. McCauley	130 E. Fort Ave.

VS 150

63B

970358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B 970.2 D 970358

Register (or) No. H 9715 970358

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Clyde Dawson LYNN

2. DATE OF DEATH January 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland University Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore 43 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland COUNTY Hopkins Apts,
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, 12-2
D. STREET ADDRESS (If rural, give location) 4[illegible] Hopkins Apartments. St. Paul & 31st. Sts.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Jany 29.1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	home duties	N.C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Council Dawson	Sarah Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	no	Dr. Wm. D. Lynn, Son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Barbiturate poisoning
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	Hopkins Apartments

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Jan. 6, 1949 Approx. 6 p. m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Overdose -- suicidal

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
Wm. D. Lynn M.D.		Jan. 8. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	jany 10.1949	Druid Ridge Cemetery	Pikesville

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 10 1949	Lenington for Williams, M.D.	John O. Mitchell Sons Co.	1900 Eutaw Place

VS 151

163B

70359

BALTIMORE CITY HEALTH DEPARTMENT 561.3 G70359 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynew Ave. + Dukeland St.
(c) Hospital or institution West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Curtis Bay (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Locust St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Josephine Budahazy
(b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married
(b) Name of husband or wife Andrew Budahazy
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) June 15, 1883
8. AGE: Years 65 | Months 6 | Days 24 | If less than one day ____ hr. ____ min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Antoni
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Andrew Budahazy
(b) Address 1625 Locust St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13 1949 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co. Md.
18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave
19 (a) JAN 10 1949 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9 1949, at 9 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1948 to 1/9 1949, and that I last saw her alive on 1/9 1949.

Immediate cause of death Peritonitis. Undetermined — Duration
Due to Intestinal Obstruction
Due to
Other Conditions Fecal Fistula (Transverse colon)
(Include pregnancy within 3 months of death)
Date of operation 12/11/48
Major findings of operation: Intestinal obstruction - Ventral hernea
of autopsy: Fecal Fistula

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John E. Ronnie M. D.
Address West Balt. Gen. Hosp. Date signed 9 Jan 49.

VS 150

122a

C70360

BALTIMORE CITY HEALTH DEPARTMENT 002V

CERTIFICATE OF DEATH

Registered No. C70360

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alexander T. Fialkowski

2. DATE OF DEATH Jan. 8 - 1949

3. PLACE OF DEATH: Baltimore City, Maryland 705 S. Oldham St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 26-7
D. STREET ADDRESS (If rural, give location) 705 S. Oldham St

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Feb 20 1896
9. AGE (In years last birthday) 52 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboer
10B. KIND OF BUSINESS OR INDUSTRY Kelch Bros.
11. BIRTHPLACE (State or foreign country) Balto. Md
12. CITIZEN OF WHAT COUNTRY? yes

13. FATHER'S NAME Simon Fialkowski
14. MOTHER'S MAIDEN NAME Marguite Tomczak

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-05-2765
17. INFORMANT Frank Fialkowski ADDRESS 3710 Harlem Ave

18. CAUSE OF DEATH

		(INTERVAL BETWEEN ONSET AND DEATH)
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary Tuberculosis.	Nov 10/48
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 11-10-48 19__, *to* 1-8-49 19__, *that I last saw the deceased alive on* 1-8-, 19 49, *and that death occurred at* 6 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE F. G. Schumunk M. D.
23B. ADDRESS 842 S. Eaton Ave
23C. DATE SIGNED 1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Jan 12-1949
24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus
24D. LOCATION (City, town, or county) (State) Balto. City

DATE RECEIVED BY LOCAL REGISTRAR JAN 10 1949
REGISTRAR'S SIGNATURE H. Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm. S. Fialkowski ADDRESS 2207 Eastern Ave

VS 150

313

G70361 434.3 G70361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Stephen J. Kasprzak (Casper
2. DATE OF DEATH: Jan 7-1949
3. PLACE OF DEATH: a. Baltimore City, Maryland 2000 Fountain St
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2000 Fountain St
c. Length of stay in Baltimore: 35 yrs (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 2000 Fountain St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2000 Fountain St. 2-3
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 13-1903
9. AGE (In years last birthday): 45 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Ford Motor Co
11. BIRTHPLACE (State or foreign country): Phila. Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Kasprzak
14. MOTHER'S MAIDEN NAME: Mary
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-05-9915
17. INFORMANT: Anna Kasprzak ADDRESS: 2000 Fountain St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Cardiac dilatation — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 6, 1949 to Jan 7, 1949, that I last saw the deceased alive on Jan 7, 1949, and that death occurred at 5:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE: Helen V. Szczerbacki M. D.
23B. ADDRESS: 1802 Eastern Ave
23C. DATE SIGNED: 1-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 11-1949
24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus
24D. LOCATION (City, town, or county) (State): Balto. City

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Thurston Williams, M.D.
25. FUNERAL DIRECTOR: Wm. S. Tkaczowski ADDRESS: 3007 Eastern Ave

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570362

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

002

G70362

Registered No.

1. NAME OF DECEASED (Type or Print) David Burruss

2. DATE OF DEATH 1- 9- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Yrs. Life, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 929 Hollins ST. 18-2

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Nov. 24-1874 | 9. AGE (In years last birthday) 74 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN

10B. KIND OF BUSINESS OR INDUSTRY FOR CITY

11. BIRTHPLACE (State or foreign country) MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Henry Burruss

14. MOTHER'S MAIDEN NAME Hannah Beturson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Records Balto. City Hospitals ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiac disease in failure terminally — INTERVAL BETWEEN ONSET AND DEATH: — years.

DUE TO

(B) Severe urinary tract infection — 2-3 weeks

DUE TO

(C) Pulmonary tuberculosis advanced — years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized arteriosclerosis, Prostatic hypertrophy — years

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-27, 1948 *to* 1-9, 1949 *that I last saw the deceased alive on* 1-9, 1949, *and that death occurred at* 3:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Margaret A. Maggs M. D. | 23B. ADDRESS Baltimore City Hospital | 23C. DATE SIGNED 1-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1/12/49 | 24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK | 24D. LOCATION (City, town, or county) (State) 3801 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR JAN 10 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR JOHN J COWAN & SON | ADDRESS 901 HOLLINS ST

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Unglesbee. ✓

70363 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT +420.0 G70363

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Carrie B Unglesbee

2. DATE OF DEATH 1-8-49

3. PLACE OF DEATH: A. Baltimore City, Maryland University Hos

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Redwood & Greene Sts

C. Length of stay in Baltimore 2 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Howard.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ellicott City Rural
D. STREET ADDRESS (If rural, give location) Ilchester Road

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Dec. 24, 1885

9. AGE (In years last birthday) 63 If Under 1 Year: Months 0 Days 13 If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wm K Easter

14. MOTHER'S MAIDEN NAME Mollie Duvall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT J.J. Unglesbee ADDRESS Ellicott City Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intermittent Heart failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Possible Cerebro - Vascular

DUE TO

(C) Accident, Rib & Clavicle fracture

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-7-49, 19__, *to* 1-8-49, 19__, *that I last saw the deceased alive on* 1-8-49, 19__, *and that death occurred at* 7 m., *from the causes and on the date stated above.*

23A. SIGNATURE John White M. D.

23B. ADDRESS University Hospital

23C. DATE SIGNED 1-[illegible]-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1-12-49

24C. NAME OF CEMETERY OR CREMATORY Meadowridge Mem.

24D. LOCATION (City, town, or county) (State) Dorsey Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 10 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR F.C. Heginbotham ADDRESS

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MR. CHARLES A. LUTZ

2. DATE OF DEATH: 1-9-49

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE 18, MD.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BENSON, HARFORD CO.
D. STREET ADDRESS (If rural, give location):

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 8-22-1881
9. AGE (In years last birthday): 67 — If Under 1 Year: Months 4, Days 18 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: OTTO LUTZ
14. MOTHER'S MAIDEN NAME: SARAH JANE HALFAPENNY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS
DUE TO
(B) ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: HYPERTENSIVE CARDIOVASCULAR DISEASE

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-6, 1949, to 1-9, 1949, *that I last saw the deceased alive on* 1-9, 1949, *and that death occurred at* 8 5/8 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Frank Snyder, III, M. D.
23B. ADDRESS: Union Memorial Hosp
23C. DATE SIGNED: Jan 10 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 12 1949
24C. NAME OF CEMETERY OR CREMATORY: Baldair Memorial Gardens
24D. LOCATION (City, town, or county) (State): Belair, Harford Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: W. H. Archer
ADDRESS: Benson Md

VS 150

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G70365 **CERTIFICATE CORRECTED** 5-24-57 420.1 G70365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles R Ambrose

2. DATE OF DEATH: Jan 7, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland Balt.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Md. b. COUNTY Balt.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Gen. Hosp

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. Md.

Length of stay in Baltimore: Yrs. 48 Mos. Days

d. STREET ADDRESS (If rural, give location): 12-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Married	February 29, 1900	48	—	-	—	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): policeman at Work

10B. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Isaac Ambrose

14. MOTHER'S MAIDEN NAME: Mary ----

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 216-24-2410

17. INFORMANT: Mrs. June Marr ADDRESS: 805 W. 36th Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Congestive Heart Failure	2 mos.
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Coronary Thrombosis	2 mos.
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 7, 1949 *to* Jan 7, 1949, *that I last saw the deceased alive on* Jan 7, 1949 *and that death occurred at* 2:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Anthony L. Yeaman M.D. | 23B. ADDRESS: Maryland Gen. | 23C. DATE SIGNED: Jan 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 10, 1948	Loudon Park	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

VS 150

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G70366

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92

G70366 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George W. Hammond

2. DATE OF DEATH: January 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1708 Eutaw Place

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmhurst Nursing Home

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1520 Linden Avenue 14-1

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 28, 1855
9. AGE (In years last birthday): 93 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardner Retired 25 yrs.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John M. Hammond
14. MOTHER'S MAIDEN NAME: Rebecca Stein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Miss Adeline Hammond ADDRESS: 525 Tunbridge Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: abt one week

DUE TO

(B) Advanced arteriosclerosis

DUE TO

(C) Chronic Nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 5th, 1949, *to* Jan. 6th, 1949, *that I last saw the deceased alive* Jan. 6, 1949, *and that death occurred at* 4:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis Lipsitz M. D.
23B. ADDRESS: 1700 Eutaw Place (17)
23C. DATE SIGNED: 1-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: January 11, 1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

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G70367 ✓ 420.1 G70367

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 11. Insurance

1. NAME OF DECEASED (Type or Print) BESSIE SNOWDEN

2. DATE OF DEATH Jan. 8, 1949

2. PLACE OF DEATH: A. Baltimore City, Maryland B. Maryland

3. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1328 Division St.

c. Length of stay in Baltimore 48 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1328 Division Street 17-2

5. SEX Female

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

6. DATE OF BIRTH Dec. 12, 1882

9. AGE (In years last birthday) 66

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Fisherville, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Ayers

14. MOTHER'S MAIDEN NAME Evelyn Parrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) NO. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Celestine Williams ADDRESS 1206 W. Franklin St.

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Coronary Occlusion	3 hrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	DUE TO (C)	

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-5, 1949, *to* 1-8, 1949, *that I last saw the deceased alive on* 1-5, 1949, *and that death occurred at* 3:30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE Clifford P. Alexander M. D.

23B. ADDRESS 2309 Druid Hill

23C. DATE SIGNED 1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1/12/1949

24C. NAME OF CEMETERY OR CREMATORY St. Luke

24D. LOCATION (City, town, or county) (State) Reisterstown, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR JAN 10 1949

REGISTRAR'S SIGNATURE Christopher Williams, M.D.

25. FUNERAL DIRECTOR Mrs. George H. Holland ADDRESS 1631 Druid Hill Ave.

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Ella B.Crue.

2. DATE OF DEATH: 1/9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3537 Falls Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.

D. STREET ADDRESS (If rural, give location): 3537 Falls Rd. 12-6

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed.

8. DATE OF BIRTH: Dec 3,1870 | 9. AGE (In years last birthday): 79 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dennis Carter.

14. MOTHER'S MAIDEN NAME: Louisa Allender.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): -

(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO: -

17. INFORMANT: Verna Scholl ADDRESS: 3537 Falls Rd.

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic Heart Disease	2 years
	DUE TO	
ANTECEDENT CAUSES	(B) generalized arteriosclerosis	20 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 10 1946 *to* Jan 9 1949 *that I last saw the deceased alive on* Jan 8 1949 *and that death occurred at* 6 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Wallenstein M.D. | 23B. ADDRESS: 848 W 36th St | 23C. DATE SIGNED: 1/10/49

BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 1/11/49 | 24C. NAME OF CEMETERY OR CREMATORY: Fork Methodist | 24D. LOCATION (City, town, or county) (State): Fork Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Paul E.Chenoweth Jr. ADDRESS: 3615-17 Chestnut Ave.

VS 150

927

BS-125798
G70369
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

002 G70369
Registered No.

1. NAME OF DECEASED (Type or Print): Louis Guizzard (Guizzardi)

2. DATE OF DEATH: Jan. 8, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 18 N. Port St. 6-3

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Sep. (Div)
8. DATE OF BIRTH: June 10, 1885
9. AGE (In years last birthday): 63 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Martino Guizzardi

14. MOTHER'S MAIDEN NAME: Catherine Barth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO

17. INFORMANT: RECORDS-BALTO. CITY HOSPITALS
ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) For Advanced pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 9 mo(?)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Extreme malnutrition — 6 mo.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-4, 1949 *to* 1-8, 1949 *that I last saw the deceased alive on* 1-8, 1949, *and that death occurred at* 7:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Margaret A. Magee M.D.
23B. ADDRESS: Baltimore City Hospital
23C. DATE SIGNED: 1-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: JAN. 11-1949
24C. NAME OF CEMETERY OR CREMATORY: HOLY REDEEMER
24D. LOCATION (City, town, or county) (State): 4430 BELAIR RD. BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: THE DIPPEL BROS.
ADDRESS: 1800 E. LOMBARD ST.

VS 150

132

G70370 ✓ 581.0 G70370

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mr. Frank Grauling

2. DATE OF DEATH: January 9, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's

3b. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 801 S. Rose 1-4

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 25, 1883

9. AGE (In years last birthday): 65 | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME: George Grauling

14. MOTHER'S MAIDEN NAME: Margaret Dunkes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mary Grauling ADDRESS: 80a S. Rose Street

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Cirhosis of Liver
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 6, 1949 *to* Jan. 9, 1949, *that I last saw the deceased alive on* Jan. 9, 1949, *and that death occurred at* 11:45a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ray C. Parsons Jr. M. D.

23b. ADDRESS: 1400 N. Caroline

23c. DATE SIGNED: Jan. 9, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 1/13/48

24c. NAME OF CEMETERY OR CREMATORY: Oak Lawn (Cemetery)

24d. LOCATION (City, town, or county) (State): 7225 Eastern Ave. Balto. 24

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Lilly and Zeiler, Inc. 403 S. Wolfe St.

VS 150

1248

70371

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.1

Registered No. G70371

1. NAME OF DECEASED (Type or Print): Ella Givens (Givens)

2. DATE OF DEATH: January 7, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2723 Fait Ave.

3b. Length of stay in Baltimore: 84 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
2723 Fait Ave. Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2723 Fait Ave. 1-4

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 6, 1864
9. AGE (In years last birthday): 84
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel Eaton
14. MOTHER'S MAIDEN NAME: Mary Carr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Florence Goodwin- 2723 Fait Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) Cardio Vascular Degeneration
DUE TO
(B) Endarteritis Obliterans &
DUE TO Arterio Sclerosis
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 7 1948 *to* Jany 7 1949, *that I last saw the deceased alive on* Jany 6, 1949, *and that death occurred at* 7 15 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John V. Clifto M. D.
23B. ADDRESS: 5010 Greenleaf Road
23C. DATE SIGNED: 1-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Gwynn Oak Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lilly and Zeiler, Inc. ADDRESS: 403 S. Wolfe St.

VS 150

937

G70372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

401.2

Registered No. G70372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 N. Fulton ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 N. Fulton ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Walter L. Robinson Sr.

3 (b) If veteran, name war W.W 2

3 (c) Social Security Account No. 217-61-9742

4. Sex m

5. Color or race c

6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Elizabeth Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9, 1911

8. AGE: Years 37 | Months | Days | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Walter Robinson Sr.
13. Birthplace N.C.

MOTHER
14. Maiden Name Dairy Cruston
15. Birthplace N.C.

16 (a) Informant Daisy Robinson
(b) Address 131 Quincy Pl. N.W. Wash D.C.

17 (a) Burial (b) Date thereof 1/11/49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pine Hurst N.C.
Location N. C.

18 (a) Funeral director George E. Nelson
(b) Address 1303 Pennsylvania Ave.

19 (a) JAN 10 1949 (b) Certified from William [illegible], M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1949, at 4:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4/49 19 to 1/7/49 19, and that I last saw h[illegible] alive on 1/7/49 at [illegible].

Immediate cause of death Acute Myocarditis — Duration 1 wk.
Due to Rheumatic Heart Disease (? Rheumatic fever) — (?)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. J. Julian M.D.
Address 511 N. Schroeder St. Date signed 1/7/49

VS 3

58c

70373 ✓ 420.1 G70373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mabel M. Blummer

2. DATE OF DEATH 1-7-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp

C. Length of stay in Baltimore 16 yrs. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 4413 Asbury Ave 26-2

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH April 2, 1889 | 9. AGE (In years last birthday) 59 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Illinois (Chicago)

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Richard J. Goetzen

14. MOTHER'S MAIDEN NAME Isabelle Carruthers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO no

17. INFORMANT Walter Blummer ADDRESS Same

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Infarction — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular heart disease — DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-7-49, 19__, *to* 1-7-, 1949 *that I last saw the deceased alive on* 1-7, 1949, *and that death occurred at* 11:07 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE John M. Beuhrer M. D. | 23B. ADDRESS Mercy | 23C. DATE SIGNED 1-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1/11/49 | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 10 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR WM. J. TICKNER & SONS | ADDRESS Baltimore, Md

VS 150

61

70374 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 201

Registered No. G70374

1. NAME OF DECEASED (Type or Print): Richard John Tamulonis

2. DATE OF DEATH: January 9, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR (If not in hospital or institution, give street address or location): St. Joseph's

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1703 E. 30th 9-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M.	W.	Single	May 5, 1923	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Junior Pressman	News-Post	Baltimore, Md.	U. S.

13. FATHER'S NAME: Anthony Tamulonis

14. MOTHER'S MAIDEN NAME: Margaret Byrne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	219-18-5862	Mrs. Lawrence J. Drane	1703 E. 30th St.

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Nov. 17, 1948 *to* January 9, 1949, *that I last saw the deceased alive on* January 9, 1949, *and that death occurred at* 2:10a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ray E. Parsons Jr. M.D.	1100 N. Caroline St.	January 9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/12/49	Holy Redeemer Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 10 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

442

70375 ✓ 143 G70375

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Thelma von hoosberg

2. DATE OF DEATH: 1-9-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1020 N. Bentalou St. 16-5

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Aug. 27. 1901
9. AGE (In years last birthday): 47 yrs.
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Andrew J. Kelly
14. MOTHER'S MAIDEN NAME: Sadie Blizzard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: no
17. INFORMANT: Mrs. Erna Markirt ADDRESS: 1908 Kennedy Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pharyngeal edema
DUE TO Stasis of Pulmonary Secretions

(C) Post Operative Radical Neck Op.
for Ca Floor of Mouth

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12-10-48 1-6-49
19B. MAJOR FINDINGS OF OPERATION: Radical Neck Op for Ca Floor of the Mouth
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-4 , 19 49, *to* 1-8 , 19 49, *that I last saw the deceased alive on* 1-8 , 19 49, *and that death occurred at* 9:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. A. Petersen M.D. M. D.
23B. ADDRESS:
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Thurgood Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

45c

G70376 ✓600.0 G70376

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) NORMAN E NELL

2. DATE OF DEATH Jan. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Sinai Hosp.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2140 Druid Park Drive 12-8

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH June 30, 1893
9. AGE (In years last birthday) 56 yrs
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegrapher
10B. KIND OF BUSINESS OR INDUSTRY P. R. R.

11. BIRTHPLACE (State or foreign country) Adams Co., Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Nell
14. MOTHER'S MAIDEN NAME Lucy Mitchman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO

17. INFORMANT Mrs. Bessie Nell ADDRESS 2140 Druid Park Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic pyelonephritis
DUE TO
(B) Hydroureter & hydronephrosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-27-, 1948, *to* 1-7, 1949 *that I last saw the deceased alive on* 1-8-, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE J. C. Harris M. D.
23B. ADDRESS
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal
24B. DATE 1/11/49
24C. NAME OF CEMETERY OR CREMATORY Red Mount Evang. Ch.
24D. LOCATION (City, town, or county) Red Mount, Pa. (State)

DATE RECEIVED BY LOCAL REGISTRAR JAN 10 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm. J. TICKNER & SONS
ADDRESS Balto., Md.

VS 150

133a

70377 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ X 260

G70377 Registered No.

1. NAME OF DECEASED (Type or Print): Charles M. Minefski
2. DATE OF DEATH: Jan. 9-1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Vandergrift
D. STREET ADDRESS (If rural, give location): 333½ Sycamore St.

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

3c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	single	4-25-1947	1 yr.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): E. Vandergrift, Pa.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Alban F. Minefski
14. MOTHER'S MAIDEN NAME: Gertrude Blankenship

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ◇
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Albin F. Minefski
ADDRESS: 333½ Sycamore St. Vandergrift, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetic coma with severe dehydration and acidosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO
(B) Diabetes Mellitus — Unknown
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-6-, 1949 *to* 1-9-, 1949 *that I last saw the deceased alive on* 1-9-, 1949 *and that death occurred at* 3:30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Sidney Johnson Vernon Jr. M. D.
23B. ADDRESS: St. Agnes Hospital Caton & Williamson Ave Balto 29 Md.
23C. DATE SIGNED: 1-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/11/49
24C. NAME OF CEMETERY OR CREMATORY: St. Gertrude Cem.
24D. LOCATION (City, town, or county) (State): Vandergrift, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

61

G70378

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 G70378
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. HELEN B. MONTGOMERY
2. DATE OF DEATH: 1-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALT. 18, MD.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
c. Length of stay in Baltimore: 13 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 12-1
D. STREET ADDRESS (If rural, give location): 100 W. 39th St. BALT. 18, MD.

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: 12-24-1871
9. AGE (In years last birthday) (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.): 77 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): NEW JERSEY
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WILLIAM S. STRYKER
14. MOTHER'S MAIDEN NAME: HELEN ATTERBURY
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. John R. Montgomery ADDRESS: Short Hills, N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — RIGGS HALL APTS, BALT.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) LEFT HEMIPLEGIA — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) Rt. CEREBRAL JASCULAR ACCIDENT
DUE TO
(C) HYPERTENSIVE CARDIOVASCULAR DISEASE

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
ARTERIOSCLEROTIC HEART DISEASE

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-31-48, 1948 *to* 1-9-49, 19__, *that I last saw the deceased alive on* 1-9-, 1949, *and that death occurred at* 3:45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Martin Lee Williams M. D.
23B. ADDRESS: Union Memorial Hosp.
23C. DATE SIGNED: 1-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/11/49
24C. NAME OF CEMETERY OR CREMATORY: ~~Trenton xxxxx~~
24D. LOCATION (City, town, or county) (State): Trenton, N. J.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

937

CERTIFICATE CORRECTED 2-16-49 ✓ 443

070.379 070.379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Jerry Washington

2. DATE OF DEATH Jan. 7, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland Baltimore, Md.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 406 E. Lafayette Ave.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 406 E. Lafayette Ave. 12-5

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Sept. 16, 1886
9. AGE (In years last birthday) 62 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY Glen L. Martin
11. BIRTHPLACE (State or foreign country) ~~Virginia~~ Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Lee Washington
14. MOTHER'S MAIDEN NAME Mary Staten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO. 219-01-1156
17. INFORMANT Mrs. Corinne Washington ADDRESS Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aortic Insufficiency 2° Cardiac Hypertrophy DUE TO — INTERVAL BETWEEN ONSET AND DEATH Sept 1947

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO —

(C) Hypertension and Sclerosis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hemiplegia

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Sept, 1947, *to* Jan 7, 1949, *that I last saw the deceased alive on* Jan 5, 1949, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Robert J Yeager M. D.
23B. ADDRESS 1429 E Monument St
23C. DATE SIGNED 1/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/11/49
24C. NAME OF CEMETERY OR CREMATORY Baltimore National
24D. LOCATION (City, town, or county) Balto. (State)

DATE RECEIVED BY LOCAL REGISTRAR JAN 10 1949
REGISTRAR'S SIGNATURE Thurlington Williams, M.D.
25. FUNERAL DIRECTOR Charles R. Law ADDRESS 602 Madison Ave

VS 150

92a

✓ 151

670380 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

670380 — Registered No.

1. NAME OF DECEASED (Type or Print): Alpherie Roy

2. DATE OF DEATH: 1-9-49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 5 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE [redacted] MC.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1517 W. Bond St. 8-6

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): (Widowed)
8. DATE OF BIRTH: 1-30-93
9. AGE (In years last birthday): 55 — If Under 1 Year: Months 11 Days 9 — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Self Employed.
11. BIRTHPLACE (State or foreign country): Rhode Island
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Joseph Roy
14. MOTHER'S MAIDEN NAME: Fannie Cormier
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No — None.
16. SOCIAL SECURITY NO: 226-22-6807
17. INFORMANT: Leona Cimino — ADDRESS: 1517 W. Bond St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Obstruction of urethra
DUE TO
(B) Carcinoma of stomach
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-17-, 1948 *to* 1-9, 1949, *that I last saw the deceased alive on* 1-9, 1949, *and that death occurred at* 8 50 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. D. Thomas, Jr. M. D.
23B. ADDRESS: Mercy Hosp
23C. DATE SIGNED: 1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-14-49
24C. NAME OF CEMETERY OR CREMATORY: Precious Blood Cemetery
24D. LOCATION (City, town, or county) (State): Woonsocket Providence County Rhode Island

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Cuthington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: George J. Ruth Inc. 1735 Hanford Ave. Dalto Md

46 B

70.81
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E N 8900 9680

Registered No. G70.81

1. NAME OF DECEASED (Type or Print): WILLIAM H BOWIE

2. DATE OF DEATH: January 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2509 Morgan Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2504 Hollins Ferry Road 25-33

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored		Aug. 14, 1920	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck driver		Annapolis, Md.	U.S.A

13. FATHER'S NAME: Frank Bowie

14. MOTHER'S MAIDEN NAME: Berth a Casey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Bertha Bowie, 250. Hollins Ferry Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation due to carbon monoxide poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ ~~CAUSE OF~~ DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	2509 Morgan Street 25/33

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Jan. 7, 1949 7.50 a.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Faulty gas jet on a portable stove

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil L Kruger M.D.		January 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	1-10-1949	Mt. Auburn	Baltimore,	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 10 1949	Huntington Williams, M.D.	Mrs Katie R Williams 322 N. Schroeder St

VS 151

178a

G70382 ✓ 420.0 G70382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Miss Adelaide Caughy

2. DATE OF DEATH Jan 8, 1949

3. PLACE OF DEATH: Baltimore City, Maryland Bon Secours Hosp.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto. City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, City
D. STREET ADDRESS (If rural, give location) 3301 St. Paul St. 12-2

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: March 3, 1864
9. AGE (In years last birthday): 84
If Under 1 Year: Months 10 Days 5
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY: ****
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: S. Hamilton Caughy
14. MOTHER'S MAIDEN NAME: Alice Pendergast

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): no ***
16. SOCIAL SECURITY NO: ****
17. INFORMANT: Mrs Kathleen C. Edwards ADDRESS: 5159 W. Grace Richmond, Va.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure
DUE TO
(B) Cardiac decompensation
DUE TO
(C) Arteriosclerotic heart disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 23, 1948 *to* Jan 8, 1949, *that I last saw the deceased alive on* Jan. 8, 1949, *and that death occurred at* 9:55 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: D. Shuhler M. D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 1/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Hill Means & Son ADDRESS: 208 W. Calvert St. Balto., Md.

VS 100

937

G70383

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153 G70383 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Dunmore St
(c) Hospital or institution: Provident 16
(d) Length of stay in hospital or inst. (~~year, mos.~~, or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 N Carey St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Reta Green (Case)
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-20-8876

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife JACK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 4, 1898

8. AGE: Years 50 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Washington D.C. (town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name John Wallace
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Belle Wallace
15. Birthplace Balto. Md

16 (a) Informant Mrs. Corene Johnson
(b) Address 402 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/49 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 Carrollton Ave

19 (a) JAN 10 1949 (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1949 at 7 OF A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14 1948 to 1/6 1949 and that I last saw her alive on 1/6 1949.

Immediate cause of death Generalized Peritonitis — Duration

Due to Ca of Sigmoid

Due to Colon

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/31/48

Major findings of operation: Ca of Sigmoid colon

of autopsy: Gen'l'd Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nell Wallace
Address 1514 Dunmore St. Date signed 1/6/49 M.D.

VS 150

46E

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 0-10384 — Registered No. G70384

1. NAME OF DECEASED (Type or Print): MRS. FELIXENA JUDGE

2. DATE OF DEATH: 1-7-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-4
D. STREET ADDRESS (If rural, give location): 726 Woodbourne Woodbourne Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F	W	M	5-28-03	45	7 / 10	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William C Phelps
14. MOTHER'S MAIDEN NAME: Emma Weber
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Arthur J. Judge (husband) ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial Neoplasm, Type undetermined

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-7-49	Aneurysm, L. frontal lobe	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-30-48, 19 , *to* 1-7-, 1949 *that I last saw the deceased alive on* 1-7-, 1949 *and that death occurred at* 11-20 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Arthur J. Judge M. D.	Mercy Hospital	1-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 11/49	New Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Creighton Williams, M.D.
25. FUNERAL DIRECTOR: Henry W. Jenkins Sons Co. ADDRESS: 4905 York Rd 12
56D

VS 150

G70385 BALTIMORE CITY HEALTH DEPARTMENT 260 G70383

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Richard Dunaja

2. DATE OF DEATH: January 8,1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 531 N. Milton Ave.,

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 44yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 531 N. Milton Avenue 7-2

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: Dec 14,1874
9. AGE (In years last birthday): 74 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Dunaja
14. MOTHER'S MAIDEN NAME: Caroline Novotny

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 216-01-1306A
17. INFORMANT: Mrs. Helena Devine - 531 N. Milton Ave. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1/7 - 1/8 49

DUE TO

(B) Chronic Myocarditis — 1/1945

DUE TO

(C) Diabetes Mellitus — 1/1945

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1945, to Jan 8, 1949, *that I last saw the deceased alive on* Jan 7 1949, *and that death occurred at* 12 30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: William L Ryaner M. D.
23B. ADDRESS: 801 W Lenwood Rd
23C. DATE SIGNED: 1/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
24D. LOCATION (City, town, or county) (State): Horner's Lane, Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: L. Schumuck Funeral Home
ADDRESS: 2161 E. Biddle St.

VS 150

61

70.386 BALTIMORE CITY HEALTH DEPARTMENT X772.0 G70.386
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) MICHAEL McGEE
2. DATE OF DEATH January 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Marriottsville
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White		July 19, 1948		5	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Clyde McGee
14. MOTHER'S MAIDEN NAME Hazel Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS Clyde McGee - Marriottsville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Upper Respiratory Infection
DUE TO
(B) Malnutrition

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Fx Left Clavicle Fx Left Palate

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Earl L Kay M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED 1-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Jan. 12, 1949
24C. NAME OF CEMETERY OR CREMATORY Family
24D. LOCATION (City, town, or county) (State) Marriottsville Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 10 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR C. Harry Weer
ADDRESS

VS 151 10 4 a

570:87 7556 ✓ 450.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G70587

1. NAME OF DECEASED (Type or Print): Susanna Gaines
2. DATE OF DEATH: 1-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3251 Chestnut Ave. 13-5

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: Feb. 20-1861
9. AGE (In years last birthday): 87 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jacob N. Gosnell (D)
14. MOTHER'S MAIDEN NAME: Mary Davis (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: 4940 Eastern Ave. Records—Baltimore City Hospitals

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	BRONCHOPNEUMONIA	3 DAYS
DUE TO (B)	GENERALIZED ARTERIOSCLEROSIS	?
DUE TO	SENILITY	?
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	HYPERTROPHIC ARTHRITIS	

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NONE
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-21, 1944, *to* 1-9, 1949, *that I last saw the deceased alive on* 1-9, 1949, *and that death occurred at* 11:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas B. Gerwyn M. D.
23B. ADDRESS: BALTIMORE CITY HOSPITALS
23C. DATE SIGNED: 1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 12-49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town or county) (State): Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ellsworth Armacost
ADDRESS: 3911 Liberty Heights Ave 107

VS 150

G70388 ✓ 022 G70388

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Michael Andriadis

2. DATE OF DEATH: Jan. 9-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-1
D. STREET ADDRESS (If rural, give location): 1241 E. Monument St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White			61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY: Lunch Room

11. BIRTHPLACE (State or foreign country): Greece

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John

14. MOTHER'S MAIDEN NAME: Lemonia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aneurysm, Aortic, Ruptured — DUE TO

(B) Syphilis, Cardio Vascular and Central Nervous System — DUE TO

(C) Generalized Sarcomatosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION: 12-17-48

19B. MAJOR FINDINGS OF OPERATION: Ext Radiation Mass Abdominal wall

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-15, 1948, to 1-9, 1949, *that I last saw the deceased alive on* 1-9, 1949, *and that death occurred at* 8:05 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.

23B. ADDRESS: St Agnes Hospital

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 13-49

24C. NAME OF CEMETERY OR CREMATORY: Greek -

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Sambras Funeral Home Inc
440 E. North Ave. 46E

G70389 Rowe ✓ +20,1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G70389

1. NAME OF DECEASED (Type or Print): Peter Rowe

2. DATE OF DEATH: Jan. 8-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 510 Park Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 31 yrs

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 510 Park Ave
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balt. Md.
D. STREET ADDRESS (If rural, give location) Same 11-3

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 2/2/1886
9. AGE (In years last birthday) 62 — If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing Maker
10B. KIND OF BUSINESS OR INDUSTRY Lumber
11. BIRTHPLACE (State or foreign country) Hickory N. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Andrew Rowe
14. MOTHER'S MAIDEN NAME Bessie Jeanette Anderson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-10-7319
17. INFORMANT James Rowe 2122 Kalmia Rd Balto Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ✓, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Ernest L Rowe M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 9 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/12/49
24C. NAME OF CEMETERY OR CREMATORY Family Plot
24D. LOCATION (City, town, or county) (State) Hickory N. C.

DATE RECEIVED BY LOCAL REGISTRAR JAN 10 1949
REGISTRAR'S SIGNATURE Thurston Williams, M.D.
25. FUNERAL DIRECTOR Frank Pelly Rice ADDRESS 322 S. High St

VS 151

94a

G70390 BALTIMORE CITY HEALTH DEPARTMENT 420.1 G70390

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): RALPH C. HELLER.

2. DATE OF DEATH: Jan. 7th. 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland D.O.A. Mercy Hosp.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL.

Length of stay in Baltimore: 62 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2408 Linden Ave. 13-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	July 29, 1885.	63	5	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mattress Mnfgr.		Charlottesville, Va.	U.S.

13. FATHER'S NAME: Morris Heller

14. MOTHER'S MAIDEN NAME: Lena Lowenstein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		214-01-1982.	Mrs. L. Hollander	2408 Linden Ave.

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary thrombosis	Sudden
DUE TO (B)	Previous coronary thrombosis	3 yrs ago 1946
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	None	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	✓	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None	✓

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
✓ m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	✓

22. *I hereby certify that I attended the deceased from* Jan 1946 *to* Jan 7th 1949 *that I last saw the deceased alive on* Jan 3rd 1949 *and that death occurred at* 1 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Frederick Lentz M. D.	Temple Gardens Bldg	Jan 7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/11/49.	Baltimore Hebrew	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 10 1949	Huntington Williams, M.D.	David Tomchein & Son	1902 Eutaw Place.

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94a

MEDICAL CERTIFICATION

0391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

G70391 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 1-3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 S. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

✓

3 (a) FULL NAME GEORGE L. HEISER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 67 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace U N (Town, county, and state)

10. Usual Occupation K

11. Industry or business N

FATHER
12. Name O
13. Birthplace U N

MOTHER
14. Maiden Name N
15. Birthplace K N

16 (a) Informant O
(b) Address W

17 (a) N (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School DEC 22 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 10 1949 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1948, at 10:55 A M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to inhalation of illuminating-gas.
Due to

Other Conditions Pulmonary tuberculosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/15/48 9:36 A M.
(b) Where did injury occur? 623 S. Patterson Park Avenue 3rd Floor.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work?
(d) Means of injury Gas heater with rubber hose attached, turned on, unlit.

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12/15/48

VS 151

X

70392 CERTIFICATE CORRECTED I-31-49 ✓ ✓ ê 913.5 G70392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. M870.2

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MAY MORRIS

2. DATE OF DEATH: January 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~Maryland~~ B. COUNTY: H. Cav. Iredell
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Harmony
D. STREET ADDRESS (If rural, give location): ~~637 West Lombard Street~~ R.F.D. 4 4-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	colored	Single	Jan. 19, 1926	23 yrs.	11	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock Rolling Store
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Olin H. Cav.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lonnie Morris.
14. MOTHER'S MAIDEN NAME: Hazel Walton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hazel Morris ADDRESS: Harmony, N. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure due to Sodium Pentothal anaesthesia.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic rheumatic heart disease.

DUE TO

(C) Recent laceration of right eye.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): University Hospital
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Lombard & Greene Streets 4/2
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 10 49 4. a.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Sodium pentothal anesthesia

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: January 10, 1949

24A. BURIAL, CREMATION OR REMOVAL (Specify): Burial
24B. DATE: 1/11/49
24C. NAME OF CEMETERY OR CREMATORY: Rocky Creek
24D. LOCATION (City, town or county) (State): Iredell Co. N.C.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: [illegible] ADDRESS

VS JAN 11 1949

195E

70393
ES-123693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70393
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alice Koons

2. DATE OF DEATH Jan. 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospitals

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 707 Edgewood St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	White	Single	Aug 6th 1874	74	5	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	U. S.

13. FATHER'S NAME Andrew Koons

14. MOTHER'S MAIDEN NAME Rebecca Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		RECORDS-BALTO. CITY HOSPITALS 3340 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) BRONCHOPNEUMONIA
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GENERALIZED ARTERIOSCLEROSIS

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NONE		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-31, 1948, *to* 1-10, 1949, *that I last saw the deceased alive on* 1-10, 1949, *and that death occurred at* 11:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas P. Jennings M. D.	BALTIMORE CITY HOSPITALS	1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	1/13/49	Mt. Olivet	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 11 1949	Huntington Williams, M.D.	Wm Cook Inc. 127 St. Paul st.

VS 150

107

0394 7544 ✓332 G70394

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70394

1. NAME OF DECEASED (Type or Print): John McClure

2. DATE OF DEATH: 1-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1910 Bolton ST. 14-1

5. SEX: M
6. COLOR OR RACE: W
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, DIVORCED (Specify): W
8. DATE OF BIRTH: June 3- 1872
9. AGE (In years last birthday): 76 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Christopher Columbus McClure
14. MOTHER'S MAIDEN NAME: Mary Strow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records Balto. City Hospitals ADDRESS: 4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebrovascular thrombosis	18 hours
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Bronchopneumonia	12 hours

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 20 1948 *to* Jan'10 1949, *that I last saw the deceased alive on* Jan'10 1949 *and that death occurred at* 12 30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: John E. Beckfold M. D.
23B. ADDRESS: Balto City Hosp.
23C. DATE SIGNED: Jan 10 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/49
24C. NAME OF CEMETERY OR CREMATORY: Brookview
24D. LOCATION (City, town, or county) (State): Rising Sun Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

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83B

0395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33X

Registered No. G70395

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland St.
(c) Hospital or institution:
West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
25-42
(d) Street No. 2603 Annapolis Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife George L. Mason

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 6, 1892

8. AGE: Years	Months	Days	If less than one day
56	11	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

MOTHER FATHER

12. Name William Robinson
13. Birthplace Baltimore, Maryland

14. Maiden Name Anne Mahaney
15. Birthplace Hanover, Maryland

16 (a) Informant George L. Mason
(b) Address 2603 Annapolis Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12, 1949 (month) (day) (year)
(c) Cemetery or crematory St. Peter's
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JAN 11 1949 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1949 at 7:44 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2/1949 to 1/9/1949 and that I last saw her alive on 1/9/1949

Immediate cause of death Cerebro-Vascular Accident — Duration

Due to Generalized arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard A. Holmbeck
Address WBGH Date signed 1/10/49 M. D.

VS 150

83a

G70396

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70396

1. NAME OF DECEASED (Type or Print): CHARLES D. FAUNCE SR.

2. DATE OF DEATH: 1/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 4-7 Baltimore
D. STREET ADDRESS (If rural, give location): 1428 N. Gay St.

5. SEX: Male
6. COLOR OR RACE: Yellow
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9/5/1884
9. AGE (In years last birthday): 64 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): China
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Charles D. Faunce Jr. ADDRESS: 1428 N. Gay St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Arterio-sclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) General Arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 8, 1949 *to* Jan 10, 1949 *that I last saw the deceased alive on* Jan 10, 1949 *and that death occurred at* 2:10 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Chas E. Faunce Jr. M.D.
23B. ADDRESS: St. Joseph Hosp
23C. DATE SIGNED: 1/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Hill
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul st.

VS 150

93D

70397

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 70397

1. NAME OF DECEASED (Type or Print): Esther Baker (BAKER)

2. DATE OF DEATH: 1/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp.
C. Length of stay in Baltimore: 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-1
D. STREET ADDRESS (If rural, give location): 609 West Franklin St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	M	1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Lith	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Willadw Baker	Gertrude

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Jacob Baker	609 W Franklin St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarct
DUE TO
(B) ASCVD, HCVD
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/7/49, 19__, *to* 1/10/49, 19__, *that I last saw the deceased alive on* 1/10/49, 19__, *and that death occurred at* 2:00 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. N. Kastner M. D.	Sinai Hosp	1/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	1-11-49	Hebrew Young Men	Baltimore	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 11 1949	Thurlington Williams, MD	Jack Lewis Inc	2100 Eastern Ave

VS 150

93D

670.98

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

20 A.1

Registered No. 670.98

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rose Weiner

2. DATE OF DEATH 1 – 9 – 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 708 E. Arlington Ave 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F	W	married	[redacted]	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) England

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Abel Woefe

14. MOTHER'S MAIDEN NAME Deborah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT [redacted] patient ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) chronic myeloid leukemia — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. acute bronchitis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 – 3 –, 1949 *to* 1 – 9 –, 1949 *that I last saw the deceased alive on* 1 – 9 –, 1949 *and that death occurred at* 7:45 pm., *from the causes and on the date stated above.*

23A. SIGNATURE John Hays Lossen M. D.

23B. ADDRESS University Hospital, Balto Md

23C. DATE SIGNED 1 – 9 – 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1 – 11 – 49

24C. NAME OF CEMETERY OR CREMATORY Woodmere Cycle

24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 11 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewis ADDRESS 2100 Eutaw Pl

VS 150

74a

0599 G70599

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45 V

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH COOKE

2. DATE OF DEATH: 1/7/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Provident Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident 1514 Division St.

c. Length of stay in Baltimore: 60yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 242 Robert St 14-1

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 3/9/1871
9. AGE (In years last birthday): 77 (If under 1 Year: Months 9, Days 28; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Winchester, Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Mack Williams
14. MOTHER'S MAIDEN NAME: Fannie Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT ADDRESS: Mrs. Annie E. Wilson-536 Gilmore St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Ruptured Anurism	3 Min
DUE TO (B)	Unknown	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		over
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Congestive heart Failure	Unknown

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 10, 1948, *to* Jan. 7, 1949, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. McDonald M. D.
23B. ADDRESS: 844 N. Carey St. Balt. Md.
23C. DATE SIGNED: 1/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Charles G. Cooper-512 N. Carrollton Ave

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT ✓ 450

CERTIFICATE OF DEATH

Registered No. 470400

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice Randolph

2. DATE OF DEATH: 1-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 40 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore MD.
D. STREET ADDRESS (If rural, give location): 2662 Flora ST. 12-3 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	W	Dec. 8-1864 ?	84 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		VA.	U.S.

13. FATHER'S NAME: (D)

14. MOTHER'S MAIDEN NAME: (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Records Balto. City Hospitals 4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Bronchopneumonia	days
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Generalized Arteriosclerosis	yrs
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12-16-49	Arteriosclerotic gangrene, R leg	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-13-48, 19__, *to* 1-9-49, 19__, *that I last saw the deceased alive on* 1-9-49, 19 49, *and that death occurred at* 1 55 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Clyde A Pitchford M. D.	4940 Eastern Ave	1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	1/13/49	Mt. Zion	Landsdown Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 11 1949	Huntington Williams, M.D.	A. Halstead.	918- Druid Hill Ave. 10

VS 150

70401 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70401

1. NAME OF DECEASED (Type or Print): CARRIE L. JACKSON

2. DATE OF DEATH: 1/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bel Air
D. STREET ADDRESS (If rural, give location): 124 Alice Ann St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	Negro	Single	3-17-1903	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	—	Bel-air, Md	U.S.A

13. FATHER'S NAME: George A. Jackson

14. MOTHER'S MAIDEN NAME: Eliza Wiggins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
NO	—	—	Mr. Howard Jackson	6 Bond St. Bel Air Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Cerebral Hemorrhage	3 Hrs.
DUE TO (B)	Hypertensive Cardio-Vascular Disease	
(C)		

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/9, 1949 *to* 1/9, 1949 *that I last saw the deceased alive on* 1/9, 1949 *and that death occurred at* 11:58 *a. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas E. Russo M.D.	St. Josephs Hosp.	1/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county), (State)
Burial	1-12-49	Gabanscke	Bel-air, Harford md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 11 1949	Huntington Williams, M.D.	Elmer E. Bullock	556 Lewis St. Havre de Grace, md

VS 150

937

0:02 B.C. 49-00131 ✓ 769.A G70:02

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 547 Bloom St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby of Agnes Stokes ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: AA | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-3-49

8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Baby of Walter Stokes
13. Birthplace Md

MOTHER 14. Maiden Name Agnes Carter
15. Birthplace St. Marys Co. Md.

16 (a) Informant Agnes Stokes
(b) Address 547 Bloom St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-49 (month) (day) (year)
(c) Cemetery or crematory St Peters Cem
Location Md

18 (a) Funeral director George B. Nelson
(b) Address 1303 Pennsylvania Ave Huntington Williams Md

19 (a) Date received JAN 11 1949 (b) Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-8 1949, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1949 to 1-8 1949 and that I last saw him alive on 1-8 1949.

Immediate cause of death Anuria — Duration

Due to Rt. Lobar Pn.

Due to Intra uterine infection?

Other Conditions Adrenal Hemorrhage (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. B. Butler M. D.
Address Provident Hosp Date signed 1/11/49

VS 159

108

70403 BALTIMORE CITY HEALTH DEPARTMENT 70403

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Patricia Ann Titman

2. DATE OF DEATH: January 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days: 8

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: N.J.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): East Orange.
D. STREET ADDRESS (If rural, give location): 115 Halstead St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Child	11-22-45	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		N.J.	

13. FATHER'S NAME: Raymond Titman

14. MOTHER'S MAIDEN NAME: Virginia Owens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease (+ ruptured arteriosus)

DUE TO

(B) Cardiac failure?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

~~Carditis~~

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Jan 10-49	Thrombosed pulmonary artery, Congenital heart	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give street address)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-2 1949 *to* 1-10 1949 *that I last saw the deceased alive on* 1-10 1949 *and that death occurred at* 2 45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. H. Mueller M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Jan 11 1949	Belleville	Orange N.J.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 11 1949	Huntington Williams, M.D.	Henry W. Jenkins Sons Co	4905 York Rd. 15E

VS 150

70404 ✓592 G70404

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): William J. McGowan

2. DATE OF DEATH: Jan. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 539 N. Lakewood Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 539 N. Lakewood Ave. 7-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	July 20, 1886	62	5	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Store keeper	Camp Holabird	Baltimore, Md.	

13. FATHER'S NAME: Lee McGowan

14. MOTHER'S MAIDEN NAME: Mollie Grace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No.		Mrs. Gladys Preis 618 N. Lakewood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	ARTERIOSCLEROSIS	2 YRS.
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	CHR. INT. NEPH.	2 YRS.
DUE TO		
(C)	HYPOSTATIC PNEUMONIA	5 DAYS.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NO		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JUNE, 1946 *to* JAN 9, 1949, *that I last saw the deceased alive on* JAN 9, 1949, *and that death occurred at* 7:35 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James F. Kavanagh M.D. M. D.	3014 McCulloh St	1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 13, 1949	Parkwood	Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 11 1949	Huntington Williams, M.D.	Ullrich Funeral Home.

VS 150

131a

70:05 331 G70:05

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Addie E. McLenahan

2. DATE OF DEATH: Jan. 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1114 N. Montford Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1114 N. Montford Ave. 8-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Sept, 13, 1880	68	3	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laundry work	Laundry	Baltimore, Md.	

13. FATHER'S NAME: Wil iam Ford

14. MOTHER'S MAIDEN NAME: Ida F. Weiker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No.		Mrs. Beatrice Ratcliffe 1203 N. Elwood Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 3 days

DUE TO

(B) Arteriosclerosis ; Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4 Jan, 1949, *to* 7 Jan, 1949, *that I last saw the deceased alive on* ..., 19..., *and that death occurred at* ... m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Arthur Fordham M. D.	1513 N. Milton Ave	8 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 11, 1949	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 11 1949	Huntington Williams, M.D.	Ullrich Funeral Home.

VS 150

83a

70106 ✓331 G70106

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Anton L.Schatz

2. DATE OF DEATH: January 10,1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 1636 N.Wolfe Street
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 77 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
b. COUNTY
1636 N.Wolfe Street Balto.Md.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location) 8-6

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 7,1871
9. AGE (In years last birthday): 77 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Die Setter
10B. KIND OF BUSINESS OR INDUSTRY: Machinery
11. BIRTHPLACE (State or foreign country): Baltimore,Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Henry Schatz (Germany
14. MOTHER'S MAIDEN NAME: Elizabeth Kohlbauer (Germany)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): None
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs.Josephine D.Schatz
ADDRESS: 1636N.Wolfe St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhages — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteri Sclerosis — 3 yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 10, 1948, to Jan. 10, 1949, *that I last saw the deceased alive on* June 8, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Isaac Fisher M. D.
23B. ADDRESS: 1823 N Mus. St.
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 13,1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Albert L. Nitz
ADDRESS: 1606 N.Chester St.

VS 150

83a

70:07 — BALTIMORE CITY HEALTH DEPARTMENT — 143 — 70:07

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): FRANCIS JAMES CAREY

2. DATE OF DEATH: Jan. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 W. 25th St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: [illegible] St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 12-6
D. STREET ADDRESS (If rural, give location): 34 West 25th St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Divorced	July 12, 1888	60	5	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lawyer	Self	Baltimore, Md.	

13. FATHER'S NAME: Francis K. Ca rey

14. MOTHER'S MAIDEN NAME: Anna Galbraith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
Yes — W.W. No 1		William P. Carey, 4210 N. Charles St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Earl L. Royston M.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* JAN. 8, 1949, *and that death occurred at* 9 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Courtland N. Kirkpatrick Jr. M.D.	6 E. Eager Street	1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/11/49	Loudon Park, Baltimore, Md.	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 11 1949	Hunterstown Williams, M.D.	William Cook, Inc, 1217 St. Paul St.

VS 150 Note: I never attended Mr. Carey. Dr. W. H. Woody did, and I substituted for Dr. Woody to pronounce Mr. Carey dead. 9-2-50

70108 BC.48-03784 204.0 ✓ BALTIMORE CITY HEALTH DEPARTMENT X G70108

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): EDWARD B. BARBAKOS
2. DATE OF DEATH: 1/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 505 Riverside Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	S	Jan. 3, 1948	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis Barbakos
14. MOTHER'S MAIDEN NAME: Ella (Sirus)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Louis Barbakos ADDRESS: 505 Riverside Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Toxemia	1 day
DUE TO (B)	Bronchopneumonia, bilateral	3 days
DUE TO (C)		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Generalized lymphoid hyperplasia	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/8 1949 *to* 1/8 1949, *that I last saw the deceased alive on* 1/8 1949, *and that death occurred at* 10 35 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Alfred H. Dann M.D.	Maryland General Hospital	1/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/11/49	Oak Lawn	Eastern Ave Rd. md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 11 1949	Huntington Williams, M.D.	John D Connelly.	Essex, md.

VS 150

7/4A

G70109

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

120.0

Registered No. G70109

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK GASTON

2. DATE OF DEATH January 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 110 North Maderia Street 6-3

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH 3-15-1896
9. AGE (In years last birthday) 52
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Annie Sherrard ADDRESS 102 N. Madison St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 1-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1-11-49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem
24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 11 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
FUNERAL DIRECTOR Elroy O. Wilson ADDRESS 1000 Brantly Ave

VS 151

937

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): (SARAH RAINE) SADIE A. RAINE

2. DATE OF DEATH: January 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1005 Valley Street 10-1

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan. 5, 1877
9. AGE (In years last birthday): 72
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: A home
11. BIRTHPLACE (State or foreign country): Kent County, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Allen
14. MOTHER'S MAIDEN NAME: Mary Boarman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Robert G. Voarman ADDRESS: 2830 Montebella Ter.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inqutry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: C. J. Lubenow M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 1-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-13-1949
24C. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery
24D. LOCATION (City, town, or county) (State): Long Green Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: E. W. Conklin ADDRESS: 924 E. Eager St.

VS 151

93D

G70111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H 47

G70111 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY F. THOMAS

2. DATE OF DEATH: January 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1233 W. Lafayette Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1233 W. Lafayette Ave

C. Length of stay in Baltimore: Yrs. One Month Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-1; D. STREET ADDRESS (If rural, give location) 1233 W. Lafayette Ave

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 1894

9. AGE (In years last birthday): 55; If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Calvert County, Md.

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Benjamine Locks

14. MOTHER'S MAIDEN NAME: Annie Livers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs Marjorie Martinez ADDRESS 1233 W. Lafayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) C. Cardio-renal vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 20 mos

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-13-, 1948 *to* 1-9-, 1949, *that I last saw the deceased alive on* 1-7-, 1949, *and that death occurred at* 8:30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm E. L. Camper M. D.

23B. ADDRESS: 639 N. Carey St. Balto.

23C. DATE SIGNED: 1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE: 1/11/49

24C. NAME OF CEMETERY OR CREMATORY: St. Mary's Cem

24D. LOCATION (City, town, or county) (State): Boyertown Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: James A Stayer ADDRESS

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G70112

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

023

Registered No. 70112

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD WEST

2. DATE OF DEATH: January 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1422 Orleans Street 5-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	colored	Single	April 18, 1912	36	12	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Accomack County, Va	U.S.A.

13. FATHER'S NAME: George West

14. MOTHER'S MAIDEN NAME: Birdie Cropper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-vascular lues

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: January 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-16-49	Hartlast	Accomac, Va

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: J. Edgar Thomas ADDRESS: Accomac, Va

VS 151

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Dr. E. J. Alessi

BIRTH NO. 370113

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.0 443

Registered No. 670113

1. NAME OF DECEASED (Type or Print): MARGARET T. AUMILLER

2. DATE OF DEATH: Jan. 9. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6008 Sefton Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 6008 Sefton Avenue 27-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
female	white	Married	Nov. 25, 1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Maryland	

13. FATHER'S NAME: John Maurer

14. MOTHER'S MAIDEN NAME: Anna Schneider

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mr. John Aumiller, 6008 Sefton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypertensive arteriosclerotic cardiovascular disease with cerebral hemorrhage	10 days
DUE TO (B)		10 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 8 1937 *to* Jan. 9 1949, *that I last saw the deceased alive on* January 9 1949 *and that death occurred at* 4:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. J. Alessi M. D.	6217 Harford Rd	1/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-12-49	Holy Redeemer	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 11 1949	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Martha Robbins

2. DATE OF DEATH: Jan. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: 30 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 5201 Beauregard Ave. 27-9

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Married	March 9, 1895	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William Lynch

14. MOTHER'S MAIDEN NAME: Emma Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: RECORDS-BALTO. CITY HOSPITALS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Obstructive Jaundice	4 months
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Abdominal Malignancy undiagnosed	4 mo.
DUE TO		
(C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* October 1948 *to* January 1949, *that I last saw the deceased alive on* 1-8-49, 1949, *and that death occurred at* 7:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Clyde A Pitchford Jr M. D.	5610 Eastern Ave	1-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-11-49	Morland PK	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 11 1949	Huntington Williams, M.D.	L. J. Ruck	5305 Wayford

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John S. Gabbien

2. DATE OF DEATH: Jan. 8 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland —
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2343 Frederick Ave
C. Length of stay in Baltimore: Life { Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-5
D. STREET ADDRESS (If rural, give location): 2343 Frederick Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	White		12-8-1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sand Blaster	Veale-Evans. Co	Baltimore - Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William E Gabbien	Estella Greist

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	215-05-7315	Estella Gabbien	162 Calvert St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Pulmonary Tuberculosis	20 Yrs
DUE TO	Antecedent	
(B)	Silicosis	Silicosis 10 Yrs
DUE TO		
(C)	Late Laberf	Late Laterent 4

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 2/19 1941, to Jan 8, 1949, that I last saw the deceased alive on Jan 8, 1949, and that death occurred at 3:02 p. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jeannette R. Heghinian, M.D.	5528 Reisterstown Rd. (15)	1/10/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/11/1949	Mt. Olivet	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 11 1949	Huntington Williams, M.D.	O. D. Weyforth & Sons	1300 Eutaw Place

Jan 10
JEANNETTE R. HEGHINIAN, M.D.

13a 17

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

City 670116 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Oscar James Tharle

2. DATE OF DEATH 1/8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore City?

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General

C. Length of stay in Baltimore life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-9

D. STREET ADDRESS (If rural, give location) 1906 Cedric Ave #114

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	7/10/95	53				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truffic Reg

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James M. Tharle

14. MOTHER'S MAIDEN NAME Anna Merson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. 215-01-1932

17. INFORMANT Violet Christine Tharle ADDRESS 1906 Cedric Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-vascular accident - Left Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Hypertension Cardiovascular Disease — 10 yrs.?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/4 19 49 *to* 1/8 19 49 *that I last saw the deceased alive on* 1/7 19 49 *and that death occurred at* 2:20 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Charles J. Black Jr. M.D.

23B. ADDRESS Maryland General

23C. DATE SIGNED 1/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1/12/49

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 11 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR C. F. Wyckoff & Son ADDRESS 830 Eutaw Pl

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70117 E 9030 N 4335.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 70117

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Miss CATHERINE Mc MULLEN

2. DATE OF DEATH: 1/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Mercy Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital, Calvert & Saratoga
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. BALTIMORE CITY 12-2
D. STREET ADDRESS (If rural, give location): 3333 N. Charles St. #18

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: Feb. 4th 1866
9. AGE (In years last birthday): 82 (If Under 1 Year: Months: 10, Days: 24; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hugh McMullen
14. MOTHER'S MAIDEN NAME: Eliza Ryan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: REV. FR. BARRETT ADDRESS: St. Mary's Sem. Roland Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured Hip
DUE TO
(B) Cerebral Hemorrhage
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
S. G. Merrill M.D.
For: Dr. J. R. Davis M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3333 N. Charles St. #18
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1/10/49 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Fell - Collapsed and fell to floor 12/2

22. I hereby certify that I attended the deceased from 1/ , 19 , to 1/10 , 19 , that I last saw the deceased alive on 1/10 , 19 , and that death occurred at 3:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Robert E. Ewa M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/49
24C. NAME OF CEMETERY OR CREMATORY: St. Charles College Cem.
24D. LOCATION (City, town, or county) (State): Catonsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949
REGISTRAR'S SIGNATURE: Thelma Williams, M.D.
25. FUNERAL DIRECTOR: H. H. Meare and Son ADDRESS: 805 N. Calvert St.

VS 150

186a

70118 ✓ 420.1 G70118

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH GARFIELD MEYERS
2. DATE OF DEATH: JAN 9, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPH'S HOSP.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-3
c. Length of stay in Baltimore: 44 Yrs.
D. STREET ADDRESS (If rural, give location): 3331 Ramona Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	white	Married	4/29/1904	44	8	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Gas + Electric Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Wm C. Meyers
14. MOTHER'S MAIDEN NAME: Cribie Foreman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-05-5556
17. INFORMANT: Mrs Roberta Meyers ADDRESS 3331 Ramona Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Acute Coronary occlusion — 2 days
DUE TO
(C) Arterio-sclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/7 19 49 *to* 1/9 19 49 *that I last saw the deceased alive on* 1/9 19 49, *and that death occurred at* 10 55 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul E Rosenau Jr. M. D.
23B. ADDRESS: 22 Chalkhook
23C. DATE SIGNED: 1/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949
REGISTRAR'S SIGNATURE: Victor Williams, M.D.
25. FUNERAL DIRECTOR: Philip Herwig Sons
ADDRESS

VS 150

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Feinglas

70119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

002

Registered No. 070119

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32 S. Washington Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
2-1
(d) Street No. 32 S. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ossie Irene Papasrousis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Femsle	White	Married

6 (b) Name of husband or wife Gus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6 1904

8. AGE: Years	Months	Days	If less than one day
44	5	3	hr. min.

9. Birthplace Charleston, W. Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Rigor
13. Birthplace Oklahoma

MOTHER
14. Maiden Name Ida
15. Birthplace

16 (a) Informant Gus Paparousis
(b) Address 32 S. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/49 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cemetery
Location 7200 Eastern Avenue

18 (a) Funeral director Mary Weber
(b) Address 401 S. Chester St.

19 JAN 11 1949 (Date rec'd by registrar) (b) Curtis Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1949, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 1948 to Jan. 9 1949 and that I last saw h[illegible] alive on Jan. 9 1949.

Immediate cause of death Broncho-Pneumonia — Duration 2 days
Due to Pulmonary TB. — Duration ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 700 N. Rutland Date signed 1/10/49

130.

70120 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70120 Registered No.

1. NAME OF DECEASED (Type or Print): Caroline Listman — Carolyn Listman
2. DATE OF DEATH: 1/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore Gen Hosp
C. Length of stay in Baltimore: Yrs. — Mos. — Days — Few Hours

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Earleigh Hghts, (Severna Park, Md.)
D. STREET ADDRESS (If rural, give location): Truck House Road

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar. 22, 1873
9. AGE (In years last birthday): 75 — If Under 1 Year: Months 9, Days 13 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife (Retd)
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?: United State
13. FATHER'S NAME: ---------- Feuerhardt
14. MOTHER'S MAIDEN NAME: Marian Wateling
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO:
17. INFORMANT: Bertha Voigt. ADDRESS: Earleigh Heights Severna Park P.O.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Arteriosclerotic Heart Disease — ?

DUE TO

(C) Lober Pneumonia Rt Upper Lobe — '

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/9 1949, to 1/9 1949 *that I last saw the deceased alive on* 1/9 1949, *and that death occurred at* 11 50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Chas E Gilbert M. D.
23B. ADDRESS: SBGH
23C. DATE SIGNED: 1/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 12, 1949
24C. NAME OF CEMETERY OR CREMATORY: Meadow Ridge Memo.
24D. LOCATION (City, town, or county) (State): Dorsey, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Thomas W. Duglatow
ADDRESS: Glen Burnie, Md

VS 150

108

421 ✓ G70121

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1

CERTIFICATE OF DEATH

Reg. Dist. No.

PLACE OF DEATH: COUNTY: BALTIMORE — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 8 N. ANN STREET

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: BALTIMORE MD. COUNTY:

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BALTIMORE

STREET ADDRESS (If rural, give location): 8 N. ANN ST. 6-5

NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	MARY	O.	SIRKO	JAN.	8	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	white	married	1884	65 yrs.		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME: ANTHONY FURMAN

14. MOTHER'S MAIDEN NAME:

WAS DECEASED EVER IN U.S. ARMED FORCES? (No, or unknown) (If yes, give war or dates of service):

15. SOCIAL SECURITY NO.:

17. INFORMANT:

18. MEDICAL CERTIFICATION

DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	1 day
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chr. Myocard Fs	July 1948
	(c)	

OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)

19. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☐

ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—		

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

I hereby certify that I attended the deceased from Sept 1, 1948, to Dec 29, 1948 that I last saw the deceased alive on Dec 29, 1948, and that death occurred at 3 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
William L Ryan	M.D.	801 W Lanvale St	1/10/49

BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	1/12/49	Holy Cross Cem	Brooklyn	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	21. FUNERAL DIRECTOR	ADDRESS
JAN 11 1949	Huntington Williams, MD	Mary Weber	401 S. Chester St.

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G70122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70122

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARY Weber

2. DATE OF DEATH: 1-9-49

3. PLACE OF DEATH: a. Baltimore City, Maryland 3212 E. BALTIMORE ST

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 26-10
D. STREET ADDRESS (If rural, give location): 3212 E. BALTIMORE ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Widowed	Aug. 17, 1868	80				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Germany	

13. FATHER'S NAME: ? KAMM

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			MRS John Woodman	3212 E. Baltimore St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Myocardosis	
DUE TO		
(B)	Arteriosclerotic cardio-vascular disease	
DUE TO		
(C)	Arteriosclerosis. Diabetes mellitus.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-22, 1948, to 1-9, 1949 *that I last saw the deceased alive on* 1-9, 1949 *and that death occurred at* 1:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John J Gould M. D.	142 Eastern Ave.	1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-12-49	Parkwood	Baltimore. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 11 1949	Tunstall Williams, M.D.	John A. Moran	3090 E Baltimore St

VS 150

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Henry Worch	2. DATE OF DEATH: January 11, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1101 Darley Ave. c. Length of stay in Baltimore: Life (Yrs. Mos. Days)	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: Baltimore City C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland D. STREET ADDRESS (If rural, give location): 1101 Darley Ave. 9-8
5. SEX: Male 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single	8. DATE OF BIRTH: Feb. 27, 1885 9. AGE (In years last birthday): 63 yrs. If Under 1 Year: Months / Days If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mail Clerk 10B. KIND OF BUSINESS OR INDUSTRY: Gas & Elec. Co.	11. BIRTHPLACE (State or foreign country): Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Adam Worch	14. MOTHER'S MAIDEN NAME: Pauline Thurn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.: 212-05-7033	17. INFORMANT: Mrs. Florence Hauser, 1101 Darley Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Squamous cell Carcinoma of Nasopharynx. — INTERVAL BETWEEN ONSET AND DEATH: 6 Mo.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) —

DUE TO

(C) —

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1 48, to ____, 19__, *that I last saw the deceased alive on* Jan 5, 1949, *and that death occurred at* 5.20A m., *from the causes and on the date stated above.*

23A. SIGNATURE: S Gellson M. D.	23B. ADDRESS: 107 E. West St.	23C. DATE SIGNED
24A. BURIAL, CREMATION, REMOVAL (Specify): Burial	24B. DATE: Jan. 13, 1949	24C. NAME OF CEMETERY OR CREMATORY: Western Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.		
DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949	REGISTRAR'S SIGNATURE: Lexington Williams M.D.	25. FUNERAL DIRECTOR: D Gillis Amoran ADDRESS: 4510 Liberty Hgts Ave

45F

Form 150

G70124 ✓ 420.1

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70124

1. NAME OF DECEASED (Type or Print): Joseph A. Fallon

2. DATE OF DEATH: January 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2207 Homewood Avenue 9-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	single	May 10, 1893	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer	City Parks	Baltimore	U.S.A.

13. FATHER'S NAME: Frank I. Fallon

14. MOTHER'S MAIDEN NAME: Catherine Grogan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes		Mrs. Bessie Robinson	2207 Homewood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED: 9 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Jan. 12, 1949	Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 11 1949	Huntington Williams, MD	Rita Wiedefeld	900 E. Biddle Street

V9-151

94a

G70125 JL - 121750

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

007

G70125 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Eleanor Johnson

2. DATE OF DEATH: Jan. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 663 W. Fayette St. 4-2

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Married	Nov. 7, 1915	33	2	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Wauldhauser

14. MOTHER'S MAIDEN NAME: Tena Roubal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: B. C. H. ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary t. b.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 2, 1948, *to* Jan. 10, 1949 *that I last saw the deceased alive on* Jan. 10, 1949, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Dr. L Stayle Burton M. D.

23B. ADDRESS: Baltimore City Hospitals

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/14/49

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Clarence F. Hoffmann ADDRESS: 1639 Broadway

VS 150

136

B.C.H. 67537

70126 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70126 Registered No.

1. NAME OF DECEASED (Type or Print): Mary Ellen Feild

2. DATE OF DEATH: 1 - 10 - 49

3. PLACE OF DEATH: A. Baltimore City, Maryland / St. Agnes Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital.

c. Length of stay in Baltimore: 16 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 120 Melvin Ave.

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S.
8. DATE OF BIRTH: Jan. 10, 1947
9. AGE (In years last birthday): 2 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William A. Feild
14. MOTHER'S MAIDEN NAME: Rebecca J. Stromberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. William A. Feild ADDRESS: 120 Melvin Ave. Catonsvi

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARDIO-RESPIRATORY FAILURE
DUE TO
(B) RETICULOENDOTHELEOSIS
DUE TO
(C) ANEMIA

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 4:45 P. M., from the causes and on the date stated above.*

23A. SIGNATURE: John W. Shaw M. D.
23B. ADDRESS: St. Agnes Hosp.
23C. DATE SIGNED: 1/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county), (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

55E

✓ 762.5

070127

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B.C.49-00265 Registered No. 070127

1. NAME OF DECEASED (Type or Print): BABY Joseph SummERLin
2. DATE OF DEATH: 1-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTIMORE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon SECOURS HOSPITAL
c. Length of stay in Baltimore: 6 hrs. 20 min (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
2453 BARCLAY ST.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 12-3
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	White	SINGLE	1-10-49			6 20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—		

13. FATHER'S NAME: Richard Summerlin
14. MOTHER'S MAIDEN NAME: Georgia HARRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Bon Secours - Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital Atelectasis + Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Immaturity — 6 mos.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gestation 6 mos

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-10 19 49 *to* 1-10 19 49 *that I last saw the deceased alive on* 1-10 19 49, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard C Hayden M. D.	Bon Secours Hosp	1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	1-11-49	St Peters	Bush Rom & Lorraine Cem

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JAN 11 1949	Huntington Williams, M.D.	Earl B Robertson 1403-E-25th St.

VS 150

159

G70428

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 ✓ Registered No. G70428

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 W. 24th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
12-7
(d) Street No. 102 W. 24th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. HART

3 (b) If veteran, name war	3 (c) Social Security Account No.
-----	-----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William H. Hart
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) August 7, 1885

8. AGE: Years	Months	Days	If less than one day
63	5	1	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation House Work.
11. Industry or business At Home.

FATHER
12. Name Conrad Breidenbaugh
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Priegel
15 Birthplace Balto., Co., Md.

16 (a) Informant William H. Hart
(b) Address 102 W. 24th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12 49. (month) (day) (year)
(c) Cemetery or crematory St. John's Cemetery
Location Long Green, Md.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 901 S. Conkling St.

19 (a) JAN 11 1949 (b) Received by Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 49 11:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 3, 1948 to Jan. 8, 1949 and that I last saw her alive on January 8 1949.

Immediate cause of death Myocardial failure, acute, subsequent to hypertension & general carcinomatosis. — Duration: Malignancy-1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 7/17/48
Major findings of operation: Corcinoma of left breast with axillary gland involvement.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. McElwee M. D.
Address 31 E. North Ave. Date signed 1/11/49

VS 150

H. B. McElwee 50

B.C.-48-24852 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

Registered No. 170129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
4-2
(d) Street No. 663 W. Mulberry st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice Bernard Joe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/14/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joe Scott
13. Birthplace Dunton S.C.

MOTHER
14. Maiden Name Rosa Joe
15. Birthplace Darlington, S.C.

16 (a) Informant Miss Rea Joe.
(b) Address 663 W. Mulberry St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 11/17/48. (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 NOV 17 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 48

20. DATE OF DEATH Nov. 15 1948 at 2:06 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1948 to 11/15 1948, and that I last saw him alive on 11/15 1948.

Immediate cause of death	Duration
Resp. failure	
Due to Central Resp. Depress.	
Due to Cerebral Edema	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pulmonary Congestion

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Harland Chisolm M.D.
Address 902 W. Franklin Date signed 11-8-48

VS 150

670430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 670430

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELMER MACDONALD

2. DATE OF DEATH: January 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3310 Hudson Street 26-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Married	2-16-1888	60	10	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Balto. Md.	

13. FATHER'S NAME: John Mc Donald

14. MOTHER'S MAIDEN NAME: Elizabeth Smuck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 215-09-6133

17. INFORMANT: Mary MacDonald ADDRESS: 3310 Hudson St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George A. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: January 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City? town, or county) (State)
	1-13-49	Sacred Heart	Govanstown Hall Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 11 1949	Remington Williams, M.D.	Charles L. Zeiler 937

70131 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.0 ✓ Registered No. 670131

1. NAME OF DECEASED (Type or Print): EDNA SMITH

2. DATE OF DEATH: January 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE / B. COUNTY: Maryland, Balto: City 734 W. Fayette Street
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 734 W. Fayette Street 4-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Aug. 7, 1885	63	5	3	###	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Charles Nelson Smith

14. MOTHER'S MAIDEN NAME: Addie Ferry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	None	Mrs. Margaret E. Smith	734 Bartlet Avenue

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
A. L. Schwinck M.D.	☒	1-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	I-13-49	Western Cemetery	Baltimore City, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JAN 11 1949	Huntington Williams, M.D.	George J. Ruth, Inc. 1735 Harford Avenue

VS 151

937

70432

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

204.0 G70432

Registered No.

1. NAME OF DECEASED (Type or Print): Charles Randolph Baker

2. DATE OF DEATH: 1-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: 6 days. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 1732 E. Joppa Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	1/9/1880	69	— / 2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
JANITOR	Bldg.	Maryland.	U.S.A.

13. FATHER'S NAME: Thomas Baker

14. MOTHER'S MAIDEN NAME: Hannah Parlett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Wife.	same.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia

DUE TO

(B) Chronic lymphoid leukemia with Cachexia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 5 1949, *to* Jan 11, 1949, *that I last saw the deceased alive on* Jan 10 1949 *and that death occurred at* 3:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Frank Supplee Jr. M. D.	Union Memorial Hosp	Jan 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	1/13/49	Mt Zion Harford Co	Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 12 1949	Huntington Williams, M.D.	Wilson York Inc	

VS 150

74a

0433 ✓ 442 G70433

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): LILLIAN ALICE HARPER

2. DATE OF DEATH: Jan. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF ~~HOSPITAL OR INSTITUTION~~ (If not in hospital or institution, give street address or location): 2730 N. Howard St

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2730 N. Howard St. 12-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	Oct. 31, 1888	60	2	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): London, England

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Simpson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 003~~6~~03-3506

17. INFORMANT: Samuel J. Harper, 2730 N. Howard St. — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO

(B) Cardio Vascular disease — 2 yrs.

DUE TO

(C) Renal disease — several days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1938 *to* Jan. 11th, 1949, *that I last saw the deceased alive on* Jan 10, 1949, *and that death occurred at* 4.45 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: George W. E. Cross, M. D.

23B. ADDRESS: 28 W 25th St.

23C. DATE SIGNED: 1-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/13/49

24C. NAME OF CEMETERY OR ~~CREMATORY~~: Parkwood

24D. LOCATION (City, town, or county) (State): Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 150

1310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1 G70434 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Springfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
27-10 (d) Street No. 614 Springfield Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha M. Vollmer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Frederick C. Vollmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1879

8. AGE: Years	Months	Days	If less than one day
69	4	-	hr. min.

9. Birthplace Indiana (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name August Rosenberger
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Klein
15. Birthplace Germany

16 (a) Informant Frederick J. Vollmer (Son)
(b) Address 311 E. Fittinger Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-49 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Morgan
(b) Address 3060 E. Balt. St.

19 (a) JAN 12 1949 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1949, at 12:58 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1938 to Jan. 10, 1949, and that I last saw her alive on January 1949.

Immediate cause of death: Coronary thrombosis, precursor

	Duration
Due to Generalized arteriosclerosis	1 hour
Due to	10 years
Other Conditions Chronic myocarditis & nephritis & nephrosclerosis	10 years

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Frederick J. Vollmer
Address 6100 York Road Date signed Jan. 11, 49 M. D.

VS 150

131a

✓ 592

70435

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70435 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary H. McGowan

2. DATE OF DEATH: Jan. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 539 N. Lakewood Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 539 N. Lakewood Ave.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

7-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Dec 30, 1865	83		12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At. home		Baltimore, Md.	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No.		Mrs. Gladys Preis 618 N. Lakewood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	ARTERIOSCLEROSIS	3 YRS
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	CHR. INT. NEPH.	
DUE TO		
(C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	REACTION TO SHOCK AT DEATH OF HUSBAND 1-9-49	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JUNE, 1946 *to* JAN 10, 1949, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James F. Kavanagh M.D. M. D.	3014 Mt. Federick	1-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 14, 1949	Parkwood	Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 12 1949	Huntington Williams, M.D.	Ullrich Funeral Home

VS 150

1310

0136 443 G70436

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Ragnar Sjolander

2. DATE OF DEATH: Jan.9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5134 Chalgrove Ave.
c. Length of stay in Baltimore: 50 Yrs. Mo. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 5134 Chalgrove Ave., 27+17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Mar. 11,1882	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sea Captain	Merchant Marine	Stockholm, Sweden	U. S. A.

13. FATHER'S NAME: Peter Sjolander

14. MOTHER'S MAIDEN NAME: Kristina Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
			Mrs. Ida Sjolander, 5134 Chalgrove

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	5 days.
DUE TO (B)	Hypertensive Heart Disease	10 yrs.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 5, 1949, *to* 1/9, 1949, *that I last saw the deceased alive on* 1/9, 1949, *and that death occurred at* 5 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Earl L. Chambers M. D.	4108 Liberty Heights Ave.	1/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1/12/49	Loudon Park Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 12 1949	Huntington Williams, M.D.	C. Vernon Lonneman	4611 Park Hgts.

VS 150

937

70137 ✓ 151 G70137

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Eva Mary Thompson	2. DATE OF DEATH: Jan. 10, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland — 431 E. Lorraine Ave B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 431 Lorraine Ave C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
c. Length of stay in Baltimore: 50 Years (Yrs. Mos. Days)	D. STREET ADDRESS (If rural, give location): 431 E. Lorraine Ave 12-3
5. SEX: Female 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single	8. DATE OF BIRTH: 1880 9. AGE (In years last birthday): 68 If Under 1 Year: Months / Days If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress 10B. KIND OF BUSINESS OR INDUSTRY: Dept. Store	11. BIRTHPLACE (State or foreign country): Md 12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: ?	14. MOTHER'S MAIDEN NAME: Maryman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO: 216-07-7774 17. INFORMANT: Mr. Maryman, Wash. D. C. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) inanition asthenia — INTERVAL BETWEEN ONSET AND DEATH: about 6 or 8 months

DUE TO

(B) Extensive Carcinoma Stomach

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 1948 *to* January 10, 1949 *that I last saw the deceased alive on* January 8, 1949, *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Frances J Tibley, M. D.	23B. ADDRESS: 110 E North Ave	23C. DATE SIGNED: Jan 11, 49
24A. BURIAL, CREMATION, REMOVAL (Specify): Burial	24B. DATE: Jan. 13/49	24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore		
DATE RECEIVED BY LOCAL REGISTRAR: JAN 1 21949	REGISTRAR'S SIGNATURE: Huntington Williams, M.D.	25. FUNERAL DIRECTOR: Rita Wiedefeld 900 E. Biddle St ADDRESS

VS 150

463

70438 ✓ 420.0 G70438

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Zivia Yousem

2. DATE OF DEATH: Jan 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3803 1/2 Copley Rd
C. Length of stay in Baltimore: 36 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3803 1/2 Copley Rd 15-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow		89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work		Russia	U.S.

13. FATHER'S NAME: Chaim David

14. MOTHER'S MAIDEN NAME: Malka

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Mrs. Gang Sody - 3803 1/2 Copley Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio Vascular Disease.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1936 *to* Jan 12, 1949 *that I last saw the deceased alive on* Jan 12, 1949, *and that death occurred at* 7a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Oscar V. Hunnefarb M. D.	1501 Eutaw Pl	1/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-12-49	Rosedale	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JAN 12 1949	Thurlington Williams, M.D.	Jack Lewis Inc 2100 Eutaw Pl

VS 150

937

70139 ✓ 420.0 G70139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): TILLIE GORDON
2. DATE OF DEATH: 1-11-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt Sinia Home
C. Length of stay in Baltimore: 39 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-10; D. STREET ADDRESS (If rural, give location): 4100 Chatham Road
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 87 4
9. AGE (In years last birthday) / If Under 1 Year: Months, Days / If Under 24 Hours: Hours, Min.: 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Chaim Gordon
14. MOTHER'S MAIDEN NAME: Esther
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Maurice Gordon - ADDRESS: 4100 Chatham Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis

DUE TO

(B) arteriosclerosis

DUE TO

(C) Heart dis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-7 3:45p 19 49 *to* 1/11 19 49 *that I last saw the deceased alive on* 1/11 19 49 *and that death occurred at* 3:45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. D. | 23B. ADDRESS: 2201 Linden | 23C. DATE SIGNED: 1/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 1-12-49 | 24C. NAME OF CEMETERY OR CREMATORY: Beth Tfiloh | 24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 1 2 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

93D

70140 ✓ X 150 G70140

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Alois Stoff

2. DATE OF DEATH 1-10-49.

3. PLACE OF DEATH: A. Baltimore City, Maryland Emergency Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL

c. Length of stay in Baltimore — Yrs. 35 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md
D. STREET ADDRESS (If rural, give location) 906 Longston Rd.

5. SEX M. | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH Dec. 21, 1892 | 9. AGE (In years last birthday) 56 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | 10B. KIND OF BUSINESS OR INDUSTRY Barber Shop Penna. R.R. CO.

11. BIRTHPLACE (State or foreign country) Germany | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Heinrich Stoff

14 MOTHER'S MAIDEN NAME Barbara Youngen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO None

17. INFORMANT Wilhelm Stoff. ADDRESS 1309 N. Charles St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO Respiratory failure.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Resection of lower 1/3 of esoph. for

(C) removal of tumors.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-2-49 19__, *to* 1-10-49 19__, *that I last saw the deceased alive on* 1-10-49 19__, *and that death occurred at* 3 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE John Nightower M. D. | 23B. ADDRESS University Hospital | 23C. DATE SIGNED 1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1/13/49 | 24C. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL CEM. | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR JAN 12 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.

VS 150 BALTIMORE, MARYLAND

46a

70141

BALTIMORE CITY HEALTH DEPARTMENT 420.0 G70141

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): IDA MAY SCHWARTZ

2. DATE OF DEATH: January 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 9 S. Linwood Avenue
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 9 S. Linwood Avenue 1-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	Dec. 27, 1878	70yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George T. Schreck
14. MOTHER'S MAIDEN NAME: Elizabeth H. Hofferberth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. Charles M. Schwartz ADDRESS: 2704 Hamilton Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia
DUE TO
(B) Pulmonary edema
DUE TO
(C) Arteriosclerotic Heart Dis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 weeks

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. , 1949, *to* Jan 9 , 1949, *that I last saw the deceased alive on* Jan 8 , 1949, *and that death occurred at* 12:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles G MacMinn M. D.
23B. ADDRESS: 2911 E. Balto. St.
23C. DATE SIGNED: Jan 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/12/49
24C. NAME OF CEMETERY OR CREMATORY: BALTIMORE CEMETERY
24D. LOCATION (City, town or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND

93D

G-70442

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1

Registered No. 4-70442

1. NAME OF DECEASED (Type or Print): Mary E. Murphy

2. DATE OF DEATH: January 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 504 N. Paca Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Female	White		May 15, 1885	63 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Maryland	USA

13. FATHER'S NAME: Robert F. Stabler

14. MOTHER'S MAIDEN NAME: Matilda Kunkle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Mrs. William E. Paul	1637 Poplar Grove

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis.

DUE TO Coronary arteriosclerosis.

DUE TO Carbon monoxide poisoning.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	504 N. Paca Stre t

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
January 9, 1949 p.m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Inhalation of fumes from coal stove

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George G. Merrill M.D.	[ ] / [X] / [ ]	1/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-13-49	Evangelical Lutheran	Shrewsbury, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Jan. 18, 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 151

94a

✓ 422.1 G70143

G70143

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70143

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RHESA S. N. ALEXANDER

2. DATE OF DEATH: Jan. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2601 Garrison Blvd.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2601 Garrison Blvd. 15-38

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 21, 1879
9. AGE (In years last birthday): 69 — If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fire Insurance
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Alexander
14. MOTHER'S MAIDEN NAME: Anna M. Lowry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Elsie R. Alexander — ADDRESS: 2601 GarrisonBlvd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: about 2 mo
DUE TO
(B) Cardio vascular disease — about 1 yr.
DUE TO
(C) Hypo-static pneumonia — 12 hrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 21, 1948 *to* Jan 10, 1949, *that I last saw the deceased alive on* Jan 9, 1949, *and that death occurred at* 4 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter S. Tibbett, M. D.
23B. ADDRESS: 2226 Garrison Blvd
23C. DATE SIGNED: Jan 11 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem.
24D. LOCATION (City, town or county) (State): Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

93D

BIRTH NO. G70144

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

F 90 300 N 920 Registered No. G70144

1. NAME OF DECEASED (Type or Print): Marguerite Mrs. May Campbell
2. DATE OF DEATH: 1-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 18 E. Hamilton St. 11-2

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 12-26-1874
9. AGE (In years last birthday): 74 — If Under 1 Year: Months 0, Days 16 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Henry Balewine
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Dayton ADDRESS: 18 E. Hamilton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure
DUE TO
(B) Fracture left hip.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
For: Wm. C. Helfrich M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

INTERVAL BETWEEN ONSET AND DEATH: 12 days

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Fall-fract. L. hip
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Home, 18 E. Hamilton St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 11, 1949, 4:55 A.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? PT fell slipped & fell to floor

22. *I hereby certify that I attended the deceased from* Dec. 31, 1948 *to* Jan 11, 1949 *that I last saw the deceased alive on* Jan 4, 1949 *and that death occurred at* 4:55 AM *from the causes and on the date stated above.*

23A. SIGNATURE: H. Walters M D M. D.
23B. ADDRESS: Univ Mem. Hosp
23C. DATE SIGNED: 1-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-13-49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Memorial
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Wm. J. Tickner & Sons ADDRESS: Baltimore, Md.

186a

CERTIFICATE CORRECTED ~~G70448~~ ✓ 420.1 G70145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Andersen, George F.

2. DATE OF DEATH: Jan. 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. Gen'l. Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25 (Brooklyn)

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 3904 - 5th Street 25-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	June 14, 1889	59 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor & Builder	Self	Brooklyn, Md.	

13. FATHER'S NAME: William Edward Anderson

14. MOTHER'S MAIDEN NAME: ~~Laura~~ Marie Farring

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Mrs. Vera Anderson	Balto. 25 3904 -5th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MASSIVE CORONARY THROMBOSIS

DUE TO

(B) ARTERIOSCLEROIC HEART DISEASE

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/11, 1949, *to* 1/11, 1949, *that I last saw the deceased alive on* 1/11, 1949, *and that death occurred at* 3:40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Samuel P. Scalia M. D.	So. Baltimore Gen. Hosp.	1/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/15/49	Cedar Hill Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	[illegible] Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93D

G70446 BALTIMORE CITY HEALTH DEPARTMENT 722.0 G70446

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): ANNIE D. BOWEN
2. DATE OF DEATH: Jan. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2420 Linden Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2420 Linden Ave. 12-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Widow	Oct. 15, 1862	86 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	USA

13. FATHER'S NAME: Joseph J. Robinson
14. MOTHER'S MAIDEN NAME: Emily Metzger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Mr. John W. Bowen, Jr.	2420 Linden Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I (A)	Rheumatoid arthritis	4 yrs.
DUE TO (B)	no specific cause of death except age.	
DUE TO (C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 1927, *to* _____, 19___, *that I last saw the deceased alive on* 1/10, 1949, *and that death occurred at* 10 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	2020 N. Charles St	1/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/13/49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 12 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

592

B.C.H.-87958

✓154.2

G70147

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70147

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) GEORGE W KROPFELD (Kroptselder)

2. DATE OF DEATH Jan 11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 215 Battery ct

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp.

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Single	Sept 7 1947	1 Yrs	4	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME George W. Kroptselder

14. MOTHER'S MAIDEN NAME Dorothy Dopkowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO None

17. INFORMANT Father ADDRESS 215 Battery Ct.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — (INTERVAL BETWEEN ONSET AND DEATH) 4 days

DUE TO

(B) Cont [illegible]

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Interventricular Septal Defect. Cardiac Hypertrophy — From birth

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10, 1949 *to* Jan 11, 1949 *that I last saw the deceased alive on* Jan 11, 1949 *and that death occurred at* 5.05 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE Sydney A. Warren M. D. — 23B. ADDRESS Sinai Hospital, Baltimore — 23C. DATE SIGNED Jan 11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 13-49	St. Stanislaus	Dundalk Blvd

DATE RECEIVED BY LOCAL REGISTRAR — JAN 12 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS Riggel Bros. 1800 E. Lombard St

157E

G70148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

G70148 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address — 600 Eutaw St. Ext.
(c) Hospital or institution:
Pine crest Sanatarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 W. Wash. St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Butts

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife Kurvin J.C. Butts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 11, 1883

8. AGE: Years	Months	Days	If less than one day
65	9 10	12 0	hr. min.

9. Birthplace York, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Milton F. Johnson
13. Birthplace York, Pa.

MOTHER
14. Maiden Name Emma E. Holland
15. Birthplace not known

16 (a) Informant Mrs. Pauline Payne
(b) Address 923 W. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21 49 (month) (day) (year)
(c) Cemetery or crematory Rest Haven
Location Hagerstown, Md.

18 (a) Funeral director C. M. Lutz and Son
(b) Address Hagerstown, Md.

JAN 12 1949 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 11 1949, at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 6 1949, to JAN. 11 1949, and that I last saw her alive on JAN. 11 1949.

Immediate cause of death	Duration
Cerebral hemorrhage	3 hrs
Due to High blood pressure	?
Due to Generalized arterio-sclerosis	?
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin N. Borden, M. D.
Address 2030 W. Fayette St Date signed 1/12/49

VS 150

83a

Correct as reported. Physician's improperly completed certificate may be corrected.

G70149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

490 6.5 G70149
28 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Abe Johnson.

2. DATE OF DEATH: January 9, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 756 George St.
c. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 756 George St. 17-3

5. SEX: Male
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 15, 1898
9. AGE (In years last birthday): 50
If under 1 Year: Months: Days
If under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Johnson.
14. MOTHER'S MAIDEN NAME: Maggie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Berins Johnson
ADDRESS: 756 George St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia
DUE TO
(B) Malnutrition
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 wks.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/4/49, 19 49, to 1/9, 19 49, *that I last saw the deceased alive on* 1/9, 19 49, *and that death occurred at* 9 7m m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm Gerner M. D.
23B. ADDRESS: 253 Gene St
23C. DATE SIGNED: 1/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Kate R Williams
ADDRESS: 320 N Schroeder St

VS 150

108

G70450

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153

G70450 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Sarah Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Rutts Rutts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race N | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Leroy Rutts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/12/96

8. AGE: Years 52 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Howard Co, Md (Town, county, and state)

10. Usual Occupation H wife

11. Industry or business

FATHER
12. Name William Cager
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Md.

16 (a) Informant Sarah Thomas
(b) Address 1108 Sarah Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-49 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 S Schroeder St
Funeral Dir. Williams, Md.

JAN 12 1949 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1949 at 6 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1948 to Jan 8 1949 and that I last saw her alive on Jan 8 1949.

Immediate cause of death Ulcerated Carcinoma — Duration

Due to Ruptured Bowel Generalized Carcinomatosis — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation 12/28/48

Major findings of operation: Ulcerated Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address Provident Hosp Date signed 1/9/49

VS 150

46E

G70451 BALTIMORE CITY HEALTH DEPARTMENT 450.1 G70451

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 Division St
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Pitcher St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Blanche Quinn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1882

8. AGE: Years 66 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Samuel Price
13. Birthplace Md.

MOTHER 14. Maiden Name Blanche ?
15. Birthplace Baltimore, Md.

16 (a) Informant Samuel Quinn
(b) Address 634 Pitcher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 13, 1949 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 JAN 12 1949 (Date rec'd by registrar) Katie Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1949 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1948 to Jan 9 1949 and that I last saw h[illegible] alive on Jan 9 1949.

Immediate cause of death Hypostatic pneumonia — Duration
Due to Auricular fibrillation
Due to Hardening arteriosclerosis
Other Conditions Gangrene of foot
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Provident Hospital Date signed 1/9/49

VS 150

97

Mbg 3 G70152 ✓ + H20.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70152 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Earl P. Price

2. DATE OF DEATH: JAN 12 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	10-12-03	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher		Md	

13. FATHER'S NAME: Luke Price

14. MOTHER'S MAIDEN NAME: Anne Gaily

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	8 days
DUE TO (B)	Chronic passive congestion of kidneys	7 8 days
DUE TO (C)	Cardiac decompensation	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	Infection of myocardium due to hypertrophy of arteriosclerotic coronary artery, with mural thrombus, with Auricular fibrillation.	13 months 7 8 days.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-4-, 1949 *to* 1-12-, 1949 *that I last saw the deceased alive on* 1-12-, 1949 *and that death occurred at* 12:45 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Sundell M. D.	JOHNS HOPKINS HOSPITAL	Jan 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 15 1949	Bakers	Aberdeen Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 1 2 1949	Hunter Jon Williams, M.D.	Harvey Tanning Home	Aberdeen Md

VS 150

94a

G70453 Query ✓ G70453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 340.3

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARLENE ROLES Or. (Mylene Roles) D.J.K.

2. DATE OF DEATH: January 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN: (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location): 113 N. Bond St 3-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored		11-5-33	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Chauncey Roles

14. MOTHER'S MAIDEN NAME: Emma Roles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Emma Roles ADDRESS: 113 N. Bond St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningitis

DUE TO

(B) type unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

(over)

26071

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: Conrad Rey M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-13-49

24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.

24D. LOCATION (City, town, or county) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1949

REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.

25. FUNERAL DIRECTOR: Elroy S. Wilson ADDRESS: 1005 Brantley Ave

81a

G70154 ✓ H20.0 G70154

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARTHA ALLEAN RYE
2. DATE OF DEATH: 1/11/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Hosp. Women of Md,
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE HOSPITAL FOR THE Women of MD
c. Length of stay in Baltimore: Yrs. 70 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND. B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 407 E. North Ave. 12-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White.	MARRIED.	Oct 10, 1873.	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE	None.	Maryland.	USA.

13. FATHER'S NAME: SAMUEL COOMBS
14. MOTHER'S MAIDEN NAME: ELIZABETH BAILEY.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.			Alfred E. Rye (Son).	1624 E 29th St. Balt. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) THROMBOSIS ABDOMINAL AORTA — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO
(B) Arteriosclerotic cardiovascular disease — 5 or 6 years.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/10/49.	Thrombosis abdominal aorta	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/11, 1949, *to* 1/11/49., 19___, *that I last saw the deceased alive on* 1/10/49., 19___, *and that death occurred at* 6:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mark E Holt, Jr. M. D.	Women's Hospital	1/11/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/14/49	Moreland Memorial	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 14 1949	Huntington Williams, M.D.	WIEDEFELD & SON GREENMOUNT & 22ND

93D

G70455 BALTIMORE CITY HEALTH DEPARTMENT 332 G70455

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mother Mary Vincent Cuddy
2. DATE OF DEATH: January 11, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-1
8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
D. STREET ADDRESS (If rural, give location): 3725 Ellerslie Ave.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	white	single	7/26/64	84	5	16	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Religious		Ireland	

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

(B) Cerebral Thrombosis

DUE TO

(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 12, 1948, *to* Jan. 11, 1949, *that I last saw the deceased alive on* Jan 11, 1949, *and that death occurred at* 12 50 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip A. Porter M.D. M. D.	1400 N. Caroline St.	Jan 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 14 1949	St Elizabeths Home	3725 Ellerslie Ave, Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 12 1949	Huntington Williams, M.D.	Henry Hankins & Sons Co 4905 York Rd

VS 150

T3B

G70456 BALTIMORE CITY HEALTH DEPARTMENT G70456

CERTIFICATE OF DEATH

E812.9 E935.0

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CHARLOTTE HUBBARD
2. DATE OF DEATH: January 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore Gen. Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brooklyn
D. STREET ADDRESS (If rural, give location): 916 Church Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	S	10/13/1931	17	2	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Girl		Baltimore, Md.	

13. FATHER'S NAME: Milton E. Hubbard
14. MOTHER'S MAIDEN NAME: Charlotte E. (Warner)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Family -	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage, DUE TO traumatic

(B) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Compound fracture of Skull + Fibula

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street--public	Church & Maggie Street, Brooklyn, Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
1-1-49 8:25 p. m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Pedestrian struck by hit and run driver

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B.	23C. DATE SIGNED
Carl L. Reyer M.D.	CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	1-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	1/14/49	Mt. Olivet	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 12 1949	Huntington Williams, M.D.	James L. McCauley	- 130 E. Fort Av

VS 151

170c

G70157 Baierlein + V 420.0 G70157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Michael Baierlein

2. DATE OF DEATH: 1/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto Gen Hosp
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: A A.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Round Bay
D. STREET ADDRESS (If rural, give location): Ritchie Highway

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	M.	6/27/1878	70	11	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor	School.	Germany	Same.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		Family -	Same.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Infarct
DUE TO
(B) Arteriosclerotic Heart Disease Decompensated

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Left Inguinal Hernia Direct Complete

INTERVAL BETWEEN ONSET AND DEATH: (A) — (B) 4 wks (C)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from 1/10 1949, to 1/11, 1949, that I last saw the deceased alive on 1/11, 1949, and that death occurred at 2.23 P.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas C Bell Jr M. D.	SBGH	1/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B.	1/15/49	Glen Haven	Glen Burnie

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 12 1949	Huntington Williams, M.D.	James L. McCurley	130 E Fort Ave.

VS 150

937

G70458 BALTIMORE CITY HEALTH DEPARTMENT 350 G70458

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2721 N. Charles St.
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 Mt. Holly Street #22 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. MARY Heiligman (HEILIGMAN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband ~~or wife~~ late FRANK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 22, 1872

8. AGE: Years	Months	Days	If less than one day
76	3	19	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name IRA HANCOCK BAUERS
13. Birthplace VA

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant MRS LENNOX FOX
(b) Address 418 MT HOLLY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 14 '49 (month) (day) (year)
(c) Cemetery or crematory MT OLIVET
Location 2930 FREDERICK AVE

18 (a) Funeral director Henry A Wilhelm
(b) Address 4101 Edmondson Ave

JAN 12 1949 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1949, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 19..., to 1-11 1949.
and that I last saw h~~im~~ alive on 1-11 1949.

Immediate cause of death: hypostatic pneumonia — Duration
Due to Old age + Parkinsonism
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H W Scheye M. D.
Address 3924 Edmondson Date signed 1-11-49

H W Scheye 87c

G70459

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

523.0 G70459

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 S. CALHOUN ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 S. CALHOUN ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

49-3

3 (a) FULL NAME WILLIAM KLEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife JOSEPHINE (HARTZELL)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 4 1889

8. AGE: Years	Months	Days	If less than one day
59	9	6	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business B & O. R.R.

FATHER
12. Name JOHN KLEIN
13. Birthplace GERMANY

MOTHER
14. Maiden Name KATHERINE —
15. Birthplace GERMANY

16 (a) Informant MRS WILLIAM KLEIN
(b) Address 322 S. CALHOUN ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 13 1949 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Harry H Wiltshire
(b) Address 5401 Huntington Ave. Baltimore, Md.

19 (a) JAN 12 1949 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 10 1949 at M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1948 to Jan. 10 1949 and that I last saw him alive on Jan. 8 1949

Immediate cause of death	Duration
Cardio-vascular renal disease	2 yrs.
Due to Pulmonary silicosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Kerwick
Address 1934 Wilkens Ave. Date signed 1/10/49 M.D.

VS 150

131a

G70160 BALTIMORE CITY HEALTH DEPARTMENT 150 G70150 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W 40th St Balto Md
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 24
(e) Length of stay in Baltimore (yrs., mos., or days) 82

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
13-7 (d) Street No. 700 W 40th St Balto Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gerber, Missanna E

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) ~~Single, married,~~ widowed, ~~or divorced~~

6 (b) Name of husband or wife William H Gerber Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-7-1860

8. AGE: Years 89 | Months 0 | Days 3 | If less than one day hr. min.

9. Birthplace Dorchester Co Md
(Town, county, and state)

10. Usual Occupation Supt. Florence Crittenden Home

11. ~~Industry or business~~

FATHER
12. Name John North
13. Birthplace Dorchester Co Md

MOTHER
14. Maiden Name Jane Frazier
15. Birthplace Dorchester Co Md

16 (a) Informant Mrs Frances M. Hazard
(b) Address 700 W 40th St Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11 1949 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick J. Dyer
(b) Address 1700 W. Lombard St.

19 (a) JAN 12 1949 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1949 at 1:52 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1948 to 1/10 1949 and that I last saw h alive on 1/8 1949.

Immediate cause of death Myelomatosis — Duration 18 months

Due to Arteriosclerosis (Chronic) — 6 years

Due to

Other Conditions Chronic Cholecystitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W Grafton Hergenger M. D.
Address 204 Medical Arts Bldg Date signed 1/10/49

VS 150

82

H2H4E

G70461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V X 75+4

G70461 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby "Boy" Haines

2. DATE OF DEATH: JAN 12 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY: Montgomery
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarksburg
D. STREET ADDRESS (If rural, give location)

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 1-7-49
9. AGE (In years last birthday) | If Under 1 Year: Months, Days: 4 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Otis Haines
14. MOTHER'S MAIDEN NAME: Ina ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CONGENITAL MALF. OF THE HEART TYPE UNKNOWN, CYANOTIC

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-11- 1949 *to* 1-12- 1949, *that I last saw the deceased alive on* 1-12 1949, *and that death occurred at* 1.50 a *m., from the causes and on the date stated above.*

23A. SIGNATURE: Allen C. Mermann M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Montgomery Md
24B. DATE: Jan 13-1949
24C. NAME OF CEMETERY OR CREMATORY: Montgomery Mem.
24D. LOCATION (City, town, or county) (State): Montgomery Co Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1949
REGISTRAR'S SIGNATURE: [illegible]
FUNERAL DIRECTOR — ADDRESS: Roy W Barber Funeral Home

157E

G-70462 H20.1 G-70462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Carmelo J. M. Scandora
2. DATE OF DEATH: January 9. 1949.
3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
c. Length of stay in Baltimore: Life. Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 242 S. Collington ave
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug 6. 1894
9. AGE (In years last birthday): 54 — If under 1 Year: Months 6. Days 3. — If under 24 hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plant Watchman
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Salvatore Scandora
14. MOTHER'S MAIDEN NAME: Francesca Galiano
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-09-1796
17. INFORMANT — ADDRESS: MRS. ROSE SCANDORA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1/9/49

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) ARTERIOSCLEROTIC CARDIO-VASC-ULAR DISEASE — 2 MONTHS

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 5, 1948 *to* Jan. 9, 1949, *that I last saw the deceased alive on* Jan 9, 1949, *and that death occurred at* 3:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph F Strenga, M. D.
23B. ADDRESS: 209 N. Castle St
23C. DATE SIGNED: 1/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 13 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Road Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: WENDELL J DIPPEL, 812 S. Highland ave

VS 150

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G70463 BALTIMORE CITY HEALTH DEPARTMENT 422.2 G70463
CERTIFICATE OF DEATH Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3208 Foster Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Foster Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY KRAUS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 30, 1870

8. AGE: Years 78 Months 4 Days 10" If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation House-Work.

11. Industry or business At Home.

FATHER 12. Name ? Kraus

13. Birthplace Germany.

MOTHER 14. Maiden Name Walburga ?

15. Birthplace Germany.

16 (a) Informant Charles Krauss

(b) Address 3208 Foster ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-49. (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cem

Location Herman Hill Rd.

18 (a) Funeral director Charles J. Zeller.

(b) Address 901 S. Conkling St.

19 (a) 1-12-49 (Date received by local registrar) (b) Registrar

JAN 12 1949 Washington Hollands, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1949, at 9.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1949 to Jan 10 1949. and that I last saw h alive on Jan 9 1949.

Immediate cause of death Acute Myocarditis Thrombus Jan 3 — Duration 1949

Due to — 1949

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. J. Zellmann M.D.

Address 3926 Gough St. Date signed Jan 12 1949

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G70464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

480

Registered No. G70464

BIRTH NO.

1. NAME OF DECEASED (Type or Print): NELLIE CLARKE

2. DATE OF DEATH: Jan.11,1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 320 E. 26th. St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland; B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 320 East 26th Street 12-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widow	Mar.10,1865	83	11	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore,Md.	

13. FATHER'S NAME: Patrick Oshea

14. MOTHER'S MAIDEN NAME: Mary A. (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Irene M. Clarke	320 E.26th St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Lobar Pneumonia	1 day
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Influenza	3 days
	DUE TO (C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 10th. 1949, *to* Jan. 11th., 19 49 *that I last saw the deceased alive on* Jan. 10th. 19 49. *and that death occurred at* 12:40A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jacob Margolies M.D.	401 E. 25th. St. Balto. 18, Md.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/13/49	Holy Redeemer,	Baltimore,Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 13 1949	Lester Williams, M.D.	William Cook, Inc.	1217 St.Paul St.

VS 150

33a

G70465 ✓ + 430.0 G70465

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MILLER, RUTH

2. DATE OF DEATH: 1/10/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSP.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: AA Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenburnie
D. STREET ADDRESS (If rural, give location): Oakwood Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	S	June 26, 1942	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Miller	Amelia Sanford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	No	—	Mrs Amelia Miller	Oakwood Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolism

DUE TO

(B) congenital Heart Disease (Interventr. Septal Defect)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Subacute Bact. Endocarditis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(Mongolian Idiocy)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-4-, 1949, *to* 1-10, 1949 *that I last saw the deceased alive on* 1-10, 1949 *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. A. Thermann M. D.	Univ. Hosp.	1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/13/49	Glen Haven	Annapolis Blvd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 13 1949	Huntington Williams, M.D.	John F. Hennigan	715 Light St

VS 150

157E

G70466 Est 6

BALTIMORE CITY HEALTH DEPARTMENT ✓ H42 G70466

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Rollins

2. DATE OF DEATH: JAN 12 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 45 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-3
D. STREET ADDRESS (If rural, give location): 539 Washington Blvd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	8-2-86	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Lithuania	

13. FATHER'S NAME: Joseph Rollins

14. MOTHER'S MAIDEN NAME: Margaret ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.

17. INFORMANT / ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure and uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive arteriosclerotic

DUE TO

(C) cardiovascular renal disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-7-1949 *to* 1-12-1949, *that I last saw the deceased alive on* 1-12-1949, *and that death occurred at* 8:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William Q. Winternitz, M. D.	JOHNS HOPKINS HOSPITAL	[redacted]49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/15/49	Loudon Park	3801 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 13 1949	Huntington Williams, M.D.	John J. Cowan & Son	901 Hollins St.

VS 150

131a

G70467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153 G70467

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Agnes Barrett

2. DATE OF DEATH: Jan.11, 1949.

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2200 Mosby Ave., 28-3

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2200 Mosby Ave.,

c. Length of stay in Baltimore: 65 Yrs. (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	May 16,1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House-wife		Baltimore, Md.	

13. FATHER'S NAME: Richard Hennelley

14. MOTHER'S MAIDEN NAME: Margaret Scennell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	none	Mr.Maylon E.Barrett	2200 Mosby Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cancer of Colon	1 year
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 1945	Carcinoma Hepatic Flexure of Colon	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan , 19 49 *to* Jan 10, 19 49 *that I last saw the deceased alive on* , 19 , *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. C. Samuels M. D.	4509 Informity Way	Jan 11

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-14-49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 13 1949	Turrington Williams, M.D.	D. Howard Strong	3207 W. North Ave.

VS 150

466

G70368

BALTIMORE CITY HEALTH DEPARTMENT 443

CERTIFICATE OF DEATH

G70368

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DR. ALBERT SHRIER.

2. DATE OF DEATH Jan. 12, 1949.

3. PLACE OF DEATH: a. Baltimore City, Maryland 3411 Forest Park Ave

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3411 Forest Park Ave. 15-31

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	July 27, 1877.	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Physician	Physician	New York City	U.S.

13. FATHER'S NAME Frank Shrier

14. MOTHER'S MAIDEN NAME Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Mrs. Estelle W. Shrier ADDRESS 3411 Forest Park Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular [illegible] DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio-Vascular disease DUE TO — 20 yrs

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec [illegible], 19[illegible], *to* Jan 12, 1949, *that I last saw the deceased alive on* Jan 12, 1949, *and that death occurred at* 3.30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	2404 Eutaw Place	Jan 14/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	1/14/49.	Loudon Park	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
JAN 13 1949	Huntington Williams, M.D.	[illegible] Funeral Home Inc.	1902 Eutaw Place.

VS 150

937

G70469 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581.0 Registered No. G70469

1. NAME OF DECEASED (Type or Print): Robert McCadden

2. DATE OF DEATH: 1/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. Gen.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-11
D. STREET ADDRESS (If rural, give location): 923 S. Clinton St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 13 1876
9. AGE (In years last birthday): 72 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Robert McCadden
14. MOTHER'S MAIDEN NAME: Caroline Nitzel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Katherine B. McCaddin ADDRESS: 923 S. Clinton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Massive gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO
(B) Esophageal varices — ?
DUE TO
(C) Cirrhosis, hepatic, severe — ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Arteriosclerotic Heart Disease & Coronary Occlusion — ?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1-11-, 1949, *to* 1-12-, 1949, *that I last saw the deceased alive on* 1-12-, 1949, *and that death occurred at* 7 50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: William F. Haun, M. D.
23B. ADDRESS:
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/15/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Taylor Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Clarence F. Hoffmann 1639 Broadway

VS 150

124 B

BC H-59317

G70470 ✓351 G70470

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Charles R. Taber
2. DATE OF DEATH: January 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3637 Chestnut Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Since Birth (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-7
D. STREET ADDRESS (If rural, give location): 3637 Chestnut Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	Oct 13, 1946	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.A

13. FATHER'S NAME: Charles R. Taber
14. MOTHER'S MAIDEN NAME: Margaret Ricketts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Convulsions with fever of	1 day
DUE TO	undetermined origin	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Spastic Paraplegia	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* never, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Frank Supplee, Jr. M. D.	Union Memorial Hosp	Jan 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-13-49	Govans Presbyterian	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JAN 13 1949	Huntington Williams, M.D.	Ellsworth Armacost, 3911 Liberty Hgts

VS 150

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W L Bag (Hosp Dis) (Hosp Disposal)

762.5

G70371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby Boy Cooney

2. DATE OF DEATH: Jan 8 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): R = Fort Meade -
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		Jan 7, 49		1	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Floyd W. Cooney

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis — DUE TO

(B) Prematurity — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 20 hrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 7, 1949 *to* Jan. 8, 1949 *that I last saw the deceased alive on* Jan. 8, 1949, *and that death occurred at* 12 40 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William H. Zinkham M. D.	JOHNS HOPKINS HOSPITAL	1/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Hosp Disposal	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 13 1949	Huntington Williams, M.D.		

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G70472 BS-125833 ✓ 776 G70472

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B.C.-48-01862 Registered No.

1. NAME OF DECEASED (Type or Print): James, Baby Boy

2. DATE OF DEATH: Jan. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
C. Length of stay in Baltimore: 5 Days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 1511 Mountmor Ct. 15-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Single	Jan. 5, 1949	N.B.		1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	U. S.

13. FATHER'S NAME: George

14. MOTHER'S MAIDEN NAME: Lucille Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Records-Balto City Hospitals	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 5, 1949 *to* Jan 6, 1949 *that I last saw the deceased alive on* Jan 6, 1949 *and that death occurred at* 10 20 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William P. Kean M. D.	Baltimore City Hospitals	Jan. 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY/CREMATORY	24D. LOCATION (City, town or county) (State)
Cremated	1-8-49	Baltimore City Hospitals - 4940	Baltimore, Md. Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 13 1949	Huntington Williams, M.D.		

VS 150

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correct age is especially important, and physicians, please write plainly.

BIRTH NO. 570473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

260

Registered No. G70473

1. NAME OF DECEASED (Type or Print): WILFRED KENFIELD

2. DATE OF DEATH: 1-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-3
D. STREET ADDRESS (If rural, give location): 2611 E Preston St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	M	12-6-76	72		4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Canada
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: Bessie Mc Gann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT ADDRESS: Agnes Kenfield (wife) same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute Suppurative Endocarditis

(C) Diabetes Mellitus

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-7-1949 *to* 1-10-1949 *that I last saw the deceased alive on* 1-10-1949 *and that death occurred at* 11 00 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Allan F. Juld M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-14-49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR, ADDRESS: John C. Duffy Inc 2435 E Oliver St 61

VS 150

correct age is especially important. Physicians: please write the cause of death in plain English—avoid abbreviations.

141852
G70474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163 G70474
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ebb Smith

2. DATE OF DEATH: Jan 12, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md -
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore -
D. STREET ADDRESS (If rural, give location): 118 W. 22nd St 12-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Negro	Married	2-8-11	37		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck helper		Ga -	

13. FATHER'S NAME: Ebb Smith
14. MOTHER'S MAIDEN NAME: Lula Huff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	Records	JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinomatosis	
DUE TO (B)	Bronchogenic Carcinoma, left lower lobe	
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Dec. 15 1948 *to* Jan. 12, 1949 *that I last saw the deceased alive on* Jan 12, 1949, *and that death occurred at* 11 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sherman Wolbach M. D.	JOHNS HOPKINS HOSPITAL	1/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/15/49		Athens - Ga.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 13 1949	Huntington Williams, M.D.	Hallenstemeral Home J. P. Limbing	1631 Eutaw Pl

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670475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 670475

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Arlina ~~illegible~~ Arlean or ~~illegible~~ Manley

2. DATE OF DEATH: Jan. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1144 Lombard Street
c. Length of stay in Baltimore: 20 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1144 Lombard Street 18-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	Colored	Married	July 18, 1894	54 55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Suffolk, Va.	U.S.

13. FATHER'S NAME: Louis Edwards

14. MOTHER'S MAIDEN NAME: Ella Holland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Julius Manley	1144 Lombard St., Balt., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO Original site → Uterus.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11/2 1948 *to* 1/11 1949, *that I last saw the deceased alive on* 1/10 1949, *and that death occurred at* 1 00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Pinto Grant M. D.	601 N. Carrollton	1/13/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 16, 1949	Oakland Cemetery	Suffolk, Virginia

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 15 1949	Huntington Williams, M.D.	Joseph L. Russ	1200 McCulloh St., Balt., Md.

correct age is especially important. Physician: please write distinctly and use no abbreviations. Do not use ditto marks.

VS 150

48B

M M. 125037
G70476
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 443

Registered No. G70476

1. NAME OF DECEASED (Type or Print): Charles Robinson

2. DATE OF DEATH: 1-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 867 W. Franklin St. 17-3

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: DEC. 28, 1888
9. AGE (In years last birthday): 60 yrs (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William H. Robinson
14. MOTHER'S MAIDEN NAME: Estelle Ridgley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records Balto. City Hospitals ADDRESS: Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) ? (B) (C)

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NONE
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-2, 1948, *to* 1-9, 1949, *that I last saw the deceased alive on* 1-9, 1949, *and that death occurred at* 6:26 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Thomas P. Gervigon M. D.
23B. ADDRESS: BALTIMORE CITY HOSPITALS
23C. DATE SIGNED: 1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1949
REGISTRAR'S SIGNATURE: Tuttington Williams, M.D.
25. FUNERAL DIRECTOR: George G. Nelson ADDRESS: 1303 Pennsylvania Ave

VS 150

93D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G70477 ✓ 447 G70477

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Anna Monroe

2. DATE OF DEATH Jan. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 112 Asquith St.
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 112 Asquith St. 5-1

5. SEX Female
6. COLOR OR RACE Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH June 1879
9. AGE (In years last birthday) 69 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseworker
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Alice Sands. ADDRESS 1626 Madison ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Paralysis & Hypertension
DUE TO Senility
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1941 *to* Jan 9 1949 *that I last saw the deceased alive on* Jan 9 1949 *and that death occurred at* 8 A. M., *from the causes and on the date stated above.*

23A. SIGNATURE John L. Stewart M. D.
23B. ADDRESS 632 W Franklin St
23C. DATE SIGNED Jan 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Jan. 13, 1949
24C. NAME OF CEMETERY OR CREMATORY Western Star
24D. LOCATION (City, town, or county) Baltimore, Md (State)

DATE RECEIVED BY LOCAL REGISTRAR JAN 13 1949
REGISTRAR'S SIGNATURE Tennington Williams, M.D.
25. FUNERAL DIRECTOR Mrs Katie R. Williams
ADDRESS 322 N. Schroeder

VS 150

837

Correct age is especially important. Physician: please write plainly and fill in all blanks.

670:78

BALTIMORE CITY HEALTH DEPARTMENT 492 Registered No. 670:78

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before it is filed. Do not use abbreviations. If unknown, write "unknown." Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Springfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
27-10
(d) Street No. 711 Springfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James F. Dunn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age ..., years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Retired
11. Industry or business Police

FATHER 12. Name Wm. Dunn
13. Birthplace Ireland

MOTHER 14. Maiden Name Honora
15. Birthplace Ireland

16 (a) Informant Mrs Charles L. Bitzel
(b) Address 711 Springfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-49 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3006 E. Baltimore St

19 (a) JAN 1 3 1949 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1949, at 2:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1949 to Jan 11 1949. and that I last saw him alive on Jan 11 1949.

Immediate cause of death	Duration
(a) Congestive Failure (Heart)	1 hrs.
Due to Virus Pneumonia	2 days
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl F. Bauer M.D. M. D.
Address 5711 York Rd Date signed Jan 13, 1949

VS 150

109a

G70179 442 G70179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Adolph E. M. Scheiner

2. DATE OF DEATH Jan. 11/49

3. PLACE OF DEATH: a. Baltimore City, Maryland 243 S. East Ave

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 243 S. East Ave. 26-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	June 28-1873	75	6	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Watchman	Paving Contractor	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Adolph E. M. Scheiner	Bertha Husted

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Catherine Scheiner	243 S. East Ave.

MEDICAL CERTIFICATION

correct age is especially important. Physicians: please write legibly. Use ink.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cereb. Vascular Renal Disease.

DUE TO

(B) Cardiac Decompensation. Myocarditis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 7, 1947 *to* Jan 11, 1949 *that I last saw the deceased alive on* Jan 10, 1949, *and that death occurred at* 10:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward A. Flanigan Jr. M. D.	3503 Fait Ave	1-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 14/49	Oak Lawn Mem.	Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 13 1949	Huntington Williams, M.D.	John H. Miller	2334 Jefferson St.

VS 150

131a

G70180

BALTIMORE CITY HEALTH DEPARTMENT 581.0 Registered No. G70180

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Roger & Dukeland St.
(c) Hospital or institution West Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2726 Boston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophia Dzbynski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (married) widowed, or divorced.
F	W	

6 (b) Name of husband or wife Frank
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Aug 22 1902

8. AGE: Years	Months	Days	If less than one day
46	4	21	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Klauzowski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Plocharski
15. Birthplace Poland

16 (a) Informant Frank Dzbynski
(b) Address 2726 Boston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15 1949 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Ritchie Highway

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 JAN 13 1949 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12, 1949 at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8/49 to 1/12/1949. and that I last saw h[illegible] alive on 1/12/1949

Immediate cause of death — Duration

Respiratory arrest

Due to Portal Cirrhosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard A. Holombek, M.D.
Address WBGH Date signed 1/12/49

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

124 B

G70481 ✓ 153 G70481

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave + Dukeland St
(c) Hospital or institution West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
16-5
(d) Street No. 2318 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa M. Henkel

3 (b) If veteran, name war V | 3 (c) Social Security Account No. V

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	~~M~~ W

6 (b) Name of husband or wife Frank A. Henkel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6. 1868

8. AGE: Years	Months	Days	If less than one day
80	5	5	hr. min.

9. Birthplace Balto. Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Haschert
13. Birthplace France

MOTHER
14. Maiden Name Elizabeth Haas
15 Birthplace Germany

16 (a) Informant Ethel L. Henkel
(b) Address 2318 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 14/49 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location 3801 Fredrick ave

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) JAN 1 3 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11 1949, at 8 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1948 to 1/11 1949, and that I last saw her alive on 1/11 1949.

Immediate cause of death	Duration
Periotonitis	
Due to Perforation of a Carcinoma of the colon	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12/29/48
Major findings of operations: Carcinoma of colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arlyn H. Wood
Address West Balt. General Hosp Date signed 1/11/49 M.D.

VS 150

46E

G70:82 #20.1 G70:82

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MRS Carolyn Swift

2. DATE OF DEATH Jan. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home and Hospital

c. Length of stay in Baltimore 66 Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4801 Fleet St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F	W	Widowed	MAR. 24, 1882	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Maryland.	U.S.A.

13. FATHER'S NAME Mr. Philip Kraeter

14. MOTHER'S MAIDEN NAME Elizabeth Kohlhepp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		E. Palmskey	Church Home & Hosp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: Immediate

DUE TO

ANTECEDENT CAUSES

(B) Mural thrombus Left Ventricle ?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Carcinoma Rectum with metastases — Known 4 yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1945	Carcinoma Rectum	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 2 1949 *to* Jan 12 1949, *that I last saw the deceased alive on* Jan 12, 1949, *and that death occurred at* 7:40 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. McHaverd M. D.	Church Home and Hospital	1-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 15. 1949	Balto. National Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 1 31949	Huntington Williams, M.D.	Ullrich Funeral Home	

VS 150

467

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70483 ✓443 G70483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Louis Hallameyer

2. DATE OF DEATH 1-12-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE 612 b. COUNTY Clinton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
d. STREET ADDRESS (If rural, give location) 612 N Clinton 26-10

5. SEX male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH Dec 20 1889 | 9. AGE (In years last birthday) 59 59 | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk | 10b. KIND OF BUSINESS OR INDUSTRY Carpet

11. BIRTHPLACE (State or foreign country) Balto | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frank Hallameyer

14. MOTHER'S MAIDEN NAME Anna Ammen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Stephenson | ADDRESS Durham 250 Fayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Resp. failure DUE TO

ANTECEDENT CAUSES

(B) cereb - vascular accident DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) hypertension c-v disease

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-12-49 19__, *to* 1-12-49, 19__, *that I last saw the deceased alive on* 1-12-49 19__, *and that death occurred at* 12 N. *m., from the causes and on the date stated above.*

23a. SIGNATURE John White M. D. | 23b. ADDRESS University Hosp. | 23c. DATE SIGNED 1-13-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Jan 17/49 | 24c. NAME OF CEMETERY OR CREMATORY National Cem | 24d. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 1 3 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Wm. J. Funeral Home | ADDRESS 2008 Orleans

VS 150

937

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. Information is especially important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G70484 ✓ 414 G70484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles A. Schumann

2. DATE OF DEATH Jan. 13-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secour Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3017 Alameda Blvd 9-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	10-5-1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman

10B. KIND OF BUSINESS OR INDUSTRY Standard Oil

11. BIRTHPLACE (State or foreign country) Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Adam Schumann

14. MOTHER'S MAIDEN NAME Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Charlotte Schumann 3017 Alameda Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Bacterial Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

(B) Rheumatic Heart Disease — 20 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 12-26 1948 *to* 1-13 1949 *that I last saw the deceased alive on* 1-13 1949 *and that death occurred at* 5 45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Richard C. Hayden M.D.

23B. ADDRESS Bon Secours Hosp

23C. DATE SIGNED 1-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1-15-49

24C. NAME OF CEMETERY OR CREMATORY Baltimore

24D. LOCATION (City, town, or county) (State) Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 1 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR AND ADDRESS L. J. Luck 5305 Harford Rd.

95B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G70185 Certificate Corrected 1-18-49 ✓ 422.1

Dr. De Marco
Medical Arts Bldg.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70185

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward P. Smith	2. DATE OF DEATH: Jan. 11, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland; B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2040 East Federal Street	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
c. Length of stay in Baltimore: Yrs. Mos. Days	D. STREET ADDRESS (If rural, give location): 2040 East Federal Street 8-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	wodlwed	Mar. 2. (1874) 1879	(74) 69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retried		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Smith	Mary Shipley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
			Mrs. Eliz. Markert, 2040 E. Federal

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Intersatitis Myocarditis	6 years
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
No	No	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1940, 19__, *to* 1949, 19__, *that I last saw the deceased alive on* Jan 11, 19 49 *and that death occurred at* 5 A m., *from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	Medical Bldg	Jan-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	1-14-49	Oaklawn	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 13 1949	Huntington Williams, MD	L. J. Ruck, 5305 HarfordRoad

VS 150

93D

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G70486 ✓X 193 G70486

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): John G Miles
2. DATE OF DEATH: 1-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bel Air
D. STREET ADDRESS (If rural, give location): ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	W	married	Feby 28-1907	41				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber	Barber	N. C	U S

13. FATHER'S NAME: Wm Miles
14. MOTHER'S MAIDEN NAME: Minnie Edwards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes		Mrs John G Miles	Bel Air, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral hemorrhage — Interval between onset and death: 7 mo.

DUE TO

(B) Malignant neoplasm (glioma)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-12-49	Massive left right tempro-frontal glioma	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 7, 1949, *to* Jan 13, 1949, *that I last saw the deceased alive on* Jan. 13, 1949 *and that death occurred at* 3:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred R. McDermott M. D.	University Hospital	1-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jany 16/49	High Point	High Point N.C

DATE RECEIVED AND REGISTERED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 14 1949	Huntington Williams, M.D.	Joseph T Foster	Bel Air, Md

VS 150

54a

Please write clearly and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70487 ✓ 334 G70487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lucy Whalen

2. DATE OF DEATH: Jan. II 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STREET 1513 E. Lombard COUNTY St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 3-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	Col.	Widow	II.6. I879	69 69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		ST. Marys Co Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Butler	Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Edward Whalen I513 E. Lombard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemiplegia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Respiratory failure

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 5 1949 *to* Jan. 10th 1949 *that I last saw the deceased alive on* Jan 10 1949, *and that death occurred at* 10 30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marcus A Sinn M. D.	11 P Biggs St	1/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	I.I4. I949	Mt. Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 14 1949	Huntington Williams, M.D.	Elroy O. Wilson I000 Brantly Ave.

US 150

837

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70:88

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No. G70:88

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DORA KELRICK

2. DATE OF DEATH: 1/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp.

c. Length of stay in Baltimore: 45 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2825 Hilldale Avenue 15-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widower	1864	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	None	Russia	

13. FATHER'S NAME: Isaac Mandelbaum

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Mrs Fannie Raven 2825 Hilldale Ave

MEDICAL CERTIFICATION

18. 443 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular accident

DUE TO

ANTECEDENT CAUSES

(B) As C VD

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) H C VD

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Basal Cell Carcinoma

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/13/49, 19__, *to* 1/14/49 19__, *that I last saw the deceased alive on* 1/14/49, 19__, *and that death occurred at* 1:55 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lee N. Kastner M. D.	Sinai Hosp	1/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-14-49	Aitz Chaim Cong.	Washington Blvd. Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 14 1949	Huntington Williams, M.D.	Levinson Bros.	1124 W North Ave.

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ X 586 G70189

Registered No.

BIRTH NO.

Physicians: please write the causes of death clearly and legibly. Information is especially important. Be sure that correct age is entered.

1. NAME OF DECEASED (Type or Print): Mr. Henry Joseph Gerst

2. DATE OF DEATH: January 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: 59yr. 2 Mos. 20 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fullerton, Maryland RURAL
D. STREET ADDRESS (If rural, give location): Fullerton, Maryland

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: October 23, 1889
9. AGE (In years last birthday): 59 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore County, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Gerst
14. MOTHER'S MAIDEN NAME: Mary Kahl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Henry J. Gerst — ADDRESS: E. Joppa Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(B) Post-operative leakage of common duct — 14 days,
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

over

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 18, 1948 *to* Jan. 13, 1949, *that I last saw the deceased alive on* Jan. 13, 1949, *and that death occurred at* 9:15 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Joseph Kraga M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: 1-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/17/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lasasha Funeral Home — ADDRESS: 7401 Belair Rd.

VS 150

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G70490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 90-8-0 N 96

G70490 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY LORETTO AUDOUN

2. DATE OF DEATH: 1/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF ~~HOSPITAL OR INSTITUTION~~ (If not in hospital or institution, give street address or location): 902 St. Paul st.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 902 St. Paul St. 11-2

5. SEX: F
6. COLOR OR RACE: W
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED~~ (Specify): Widowed
8. DATE OF BIRTH: 5-23-1863
9. AGE (in years last birthday): 85
If Under 1 Year: Months 7 Days 20
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John A. McSherry
14. MOTHER'S MAIDEN NAME: Clementine Villers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Claire Audoun ADDRESS: 902 St. Paul St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation

DUE TO

(B) Illuminating gas

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 902 St. Paul St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 13, 1949 m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? 1 Burner partly open but unlit

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: John R. Davis M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR
23C. DATE SIGNED: 1/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/49
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul st.

VS 151

178a

Please write in ink. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

G70491

BALTIMORE CITY HEALTH DEPARTMENT A90✓

CERTIFICATE OF DEATH

Registered No. G70491

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Ray ESENDALLO (Mrs.)

2. DATE OF DEATH: 1/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hopkins Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1117 E. Pratt st. 3-2

5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED~~ (Specify): Widowed
8. DATE OF BIRTH: Jan 18th 1906
9. AGE (In years last birthday): 42
If Under 1 Year: Months 11 Days 23
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Packing Plant
11. BIRTHPLACE (State or ~~foreign country~~): Georgia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard Ray
14. MOTHER'S MAIDEN NAME: Mary Summey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Verda ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Lobar pneumonia.	
	(B) ~~Cause~~ Pericarditis	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1/11/49

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify): Burial
24B. DATE: Jan 15th 1949
24C. NAME OF CEMETERY OR ~~CREMATORY~~: Mt. Carmel
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Wm Cook Inc 1217 St Paul St.

VS-151

108

PLEASE WRITE LEGIBLY. Without alteration, erasure or mutilation. Please see that the information is complete and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B.C. 48-27509 133B

Registered No. G70192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Tell correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hospital

(c) Hospital or institution: Monument St. & Rutland Ave.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore Essex

(If outside city or town limits, write RURAL and give town)

(d) Street No. 216 Homburg Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Fuget

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 18, 1948

8. AGE: Years	Months	Days	If less than one day
			18 hr. 8 min.

9. Birthplace Sinai Hospital, Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name James Fuget

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Ida Barrow

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ida Fuget

(b) Address 216 Homburg Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School JAN 4 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JAN 7 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1948, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18-1948, to 12-18-1948, and that I last saw h alive on 12-18-1948.

Immediate cause of death Cardio-renal failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Polycystic renal disease.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert J. Weisse M.D.

Address Sinai Hospital Date signed 12/27/48

VS 150

G70493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H20.1

Registered No. G70493

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
12-5
(d) Street No. 1804 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V. Sleene

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph Sleene (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11th 1884

8. AGE: Years	Months	Days	If less than one day
64	4	1	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Dennis Leronin
13. Birthplace Ireland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Joseph Sleene
(b) Address 1804 Greenmount Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Jan 15 44 (month) (day) (year)
(c) Cemetery or crematory New Loudendal
Location Frederick Road

18 (a) Funeral director Leo. B. Cook
(b) Address 1726 N. Patterson Park Ave

19 (a) JAN 14 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12th 1949 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1948 to Jan 12 1949.
and that I last saw h alive on Jan 10 1949.

Immediate cause of death	Duration
Coronary Occlusion	7
Due to Arteriosclerosis	
Due to C. V. Disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify typical place)
(e) Means of injury

23. Signature Samuel Green M. D.
Address 1761 E. North Ave Date signed 1-14-49

VS 183
1261 E. North Ave Dr Liguns

93 D

G70494 — BALTIMORE CITY HEALTH DEPARTMENT — 443 — G70494

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Kimmerle — ELIZABETH KIMMERLE

2. DATE OF DEATH: 12 Jan 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hospital
C. Length of stay in Baltimore: Yrs. LIFE · Mos. · Days ·

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1
D. STREET ADDRESS (If rural, give location): 3204 Lawnview ave 8-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	Dec. 13, 1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: BERNHARDT KIMMERLE
14. MOTHER'S MAIDEN NAME: KATHERINE SAUER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO: none
17. INFORMANT: Miss Emma Kimmerle — ADDRESS: 3204 Lawnview Ave Baltimore - 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	2 hrs.
DUE TO (B)	Hypertensive Cardio vascular	3 yrs
DUE TO (C)	Disease	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Partial ankylosis of right hip	

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CERTIFICATION APPROVED BY
H. H. Merrill
For: Wm. H. Helfrich M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3204 Lawnview Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 12 49 2:30
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Slipped and fell to floor

22. *I hereby certify that I attended the deceased from* 12 Jan, 1949 *to* 12 Jan, 1949, *that I last saw the deceased alive on* 12 Jan, 1949, *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Richard D Hoover, M. D.
23B. ADDRESS: Univ Hospital
23C. DATE SIGNED: 12 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 15, 1949
24C. NAME OF CEMETERY OR CREMATORY: First Evangelical
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MARYLAND

VS 150

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70195 ✓ G70195

B.C.-48-2763 160a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
10-1
(d) Street No. 1207 Harford ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William maurice millner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/13/48

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore md (Town, county, and state)
10. Usual Occupation New Born
11. Industry or business

FATHER
12. Name Clarence poole
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rosie mae Smith
15. Birthplace Baltimore

16 (a) Informant Rosa m. millner
(b) Address 1207 Harford ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location
Returned by Hospital Dec. 15, 1948

18 (a) Funeral director
(b) Address

19 (a) JAN 7 1949 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1948 at 5½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1948 to 12/17 1948. and that I last saw h[illegible] alive on 12/17 1948.

Immediate cause of death	Duration
Congenital	
Due to Bilat. Hydronephrosis	
Due to Congenital	
Other Conditions Imperforate Intestinal Lesion. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: See above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Evan H Zilles
Address Provident Hosp. Date signed 1/6/49

VS 150

G70:96 B.C. 48-28635 162.0 G70:96

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Larry Davis

2. DATE OF DEATH: 1-6-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: Yrs. 5- Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-4
D. STREET ADDRESS (If rural, give location): 1705 E Chase St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
m	Negro	single	12-31-48	~~5 mos~~	5	20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N'Born Infant

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Sylvester Davis

14. MOTHER'S MAIDEN NAME: Ardella Sylvia Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: —

17. INFORMANT: Mrs Ardella S Davis ADDRESS: 1705 E Chase St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Atelectasis Bronchus.
DUE TO
(B) (& Coil of cord around neck at time of delivery)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 9

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 31, 1948, *to* Jan 6, 1949, *that I last saw the deceased alive on* Jan 5, 1949, *and that death occurred at* 3 00 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: N. Louis Jones M. D.

23B. ADDRESS: 1100 Dennison Hill St.

23C. DATE SIGNED: 1/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE:

24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School

24D. LOCATION (City, town, or county) (State):

JAN 13 1949

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Commissioner of Health

ADDRESS:

VS 150

161a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

6:0:97

BALTIMORE CITY HEALTH DEPARTMENT

B. C. 48-27998 CERTIFICATE OF DEATH 159

Registered No. 6:0:97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 2days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16-2 1020 Whatcoat (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aleatha Elzonia Joulson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	N	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/23/48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation New Born

11. Industry or business

FATHER
12. Name Herman Joulson
13. Birthplace Virginia

MOTHER
14. Maiden Name Felicia Sample
15. Birthplace Baltimore Md

16 (a) Informant: Mrs Felicia Sample
(b) Address 1020 Whatcoat St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location Johns Hopkins Medical School JAN 13 1949

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JAN 14 1949 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25- 1948, at 2.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo H Bayne Stein M.D. M. D.
Address Provident Hosp Date signed 12-2-48

VS 150

G70498

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.0 443

G70498

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Della Klein

2. DATE OF DEATH 1-13-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-1

c. Length of stay in Baltimore Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2527 Brookfield Ave

6. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years if under 1 year)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	White	Married		65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Herman Goldberg

14. MOTHER'S MAIDEN NAME Pauline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

E. INFORMANT Calman Klein - 2527 Brookfield Ave ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart Dis. Pulmonary Embolism due to

DUE TO Arteriosclerotic H.D. Hypertensive H.D.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/5, 19 49 *to* 1/13, 19 49 *that I last saw the deceased alive on* 1/13, 19 49 *and that death occurred at* 12:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE David Barlow, M. D.

23B. ADDRESS Sinai Hospital

23C. DATE SIGNED 1/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1-14-49

24C. NAME OF CEMETERY OR CREMATORY Hebrew Friendship

24D. LOCATION (City, town, or county) (State) Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 14 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc.

ADDRESS 2100 Eutaw Pl

VS 150

932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70499 ✓ 420.1 G70499

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. Kompinsky

1. NAME OF DECEASED (Type or Print): SARAH COOPER (nee) SARAH KOMPINSKY — 2. DATE OF DEATH: 1-14-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4857 Reistertown Rd

C. Length of stay in Baltimore: 45 Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-18
D. STREET ADDRESS (If rural, give location): 4857 Reistertown Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow		84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Russia	

13. FATHER'S NAME: Theodore

14. MOTHER'S MAIDEN NAME: Goldie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Sam Cooper	4857 Reistertown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Unknown 15 yr.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Apr 47, *to* Jan 17, 1949, *that I last saw the deceased alive on* Jan 14, 1949, *and that death occurred at* 1:05A m., *from the causes and on the date stated above.*

23A. SIGNATURE OF M. D.	23B. ADDRESS	23C. DATE SIGNED
Reuben N. Kolmen MD	3700 Park Heights Ave	1-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-16-49		New York N. Y.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 14 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

94a

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if obtainable. Please see that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 463

G70500

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MINNIE LANDSMAN

2. DATE OF DEATH 1/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HOSPITAL FOR THE WOMEN OF MARYLAND.

c. Length of stay in Baltimore — Yrs. 46 — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE.
D. STREET ADDRESS (If rural, give location) 2623 SPRING HILL AVE. 15-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female.	White.	MARRIED.	MARCH 25 1902	46.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	—	BALTIMORE, MD.	

13. FATHER'S NAME JACOB ZIFF

14. MOTHER'S MAIDEN NAME ANNA ~~ZIFF~~ WEINBERG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	—	—	S. LANDSMAN Husband	SAME AS WIFES

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) PULMONARY INFARCTION	12 days.
	DUE TO	
ANTECEDENT CAUSES	(B) EMBOLUS	"
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	"
	(C) THROMBOPHLEBITIS LOWER LEGS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	ARTERIOSCLEROTIC CHRDIOVASCULAR DISEASE.	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 3, 1949, to Jan 14, 1949, *that I last saw the deceased alive on* Jan 14, 1949, *and that death occurred at* 1:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mark E. Hall, Jr. M. D.	Hospital for the Women Md	1/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	1-16-49	United Hebrew	Balto	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 1 4 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

670.01 670.01

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B. C. 48-28[illegible] Registered No.

1. NAME OF DECEASED (Type or Print): BABY BOY WILSON

2. DATE OF DEATH: JAN 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for the Women of Maryland.
C. Length of stay in Baltimore: Yrs. — Mos. — Days 3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE —
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17 1-2
D. STREET ADDRESS (If rural, give location): 3313 S. Elwood Ave. Balto 17 (Parent's address)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	S.	Dec 29 1948			3	11	7

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Maryland	U. S.

13. FATHER'S NAME: William A. Wilson
14. MOTHER'S MAIDEN NAME: Mildred Elizabeth Warner.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no.	—	—	Mildred Elizabeth Wilson	3313 S. Elwood Ave. Mother

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Multiple Congenital Abnormalities (Spina Bifida, Meningocele, Imperforate Rectum) and Atelectasis.	at birth
DUE TO (B)	Intrauterine Hypoxia.	
DUE TO (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Dec 29 1948, to Jan 2, 1949, *that I last saw the deceased alive on* Jan 2, 1949, *and that death occurred at* 4:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Vernon C. Kelly M. D.	Woman's Hospital	Jan 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
		Johns Hopkins Medical School	JAN 3 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 14 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

157 B

70502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

B.C. 48-28841

Registered No. 70503

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor Ave
(c) Hospital or institution: W. Baltimore Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
20-5 (d) Street No. 2653 Frederick Ave 23 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Smithers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/28/48

8. AGE: Years	Months	Days	If less than one day
			9 hr. — min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Gerard Carl Smithers
13. Birthplace Balto Md

MOTHER
14. Maiden Name Norma Anna Funk
15. Birthplace Balto Md

16 (a) Informant Mrs Norma Smithers
(b) Address 2653 Frederick Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 31949
18 (a) Funeral director Commissioner of Health
(b) Address
19 JAN 14 1949 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1948 at 8 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 A.M. 12/28 1948 to 8 05 P.M. 12/28 1948, and that I last saw him alive on 12/28 1948.

Immediate cause of death	Duration
Atelectasis	
Due to prematurity (28 wks)	
Due to	
Other Conditions Generalized Ecchy mosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Florence L. Greenbrier M. D.
Address W. Balto. Gen. Date signed 12/28/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly in ink.

70503 B.C. 48-28692

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

762.5 G70503 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22-2 654 W. Lee St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hilton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Negro	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 12/29/48

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name Jonathan Hilton
13. Birthplace Manning, S. C.

MOTHER
14. Maiden Name Rhoda Pearl Brunson
15. Birthplace Newport News, Va.

16 (a) Informant Mother
(b) Address 654 W. Lee

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location City Hospital

18 (a) Funeral [redacted] JAN 7 1949
(b) Address Commissioner of Health

19 JAN 1 1949 (Date rec'd by registrar) (b) Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1949, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1948 to 1-1 1949.
and that I last saw h.l. alive on 1-1 1949.

Immediate cause of death Congenital Atelectasis — Duration
Due to Prematurity
Due to
Other Conditions Cleft Palate, Hare lip.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman Tarr M. D.
Address University Hosp. Date signed 1-1-49

VS 150

159

0.04

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 932 D
N 980.0

Registered No. 0.04

PLEASE WRITE PLAINLY, with pen and ink: please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. ~~(yrs., mos., or~~ days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
15-1
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 Fillmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race N | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Emma Johnson,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-10-1900

8. AGE: Years 48 | Months 11 | Days 4 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Dishwasher

11. Industry or business

FATHER
12. Name John Johnson.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Bertha Adams,
15. Birthplace Catonsville, Md.

16 (a) Informant Emma Johnson.
(b) Address 107 N. Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14, 1949 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 JAN 14 1949 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1949 at 6 30 M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 27 1948 to Jan 10 1949
and that I last saw him alive on Jan 10 1949.

Immediate cause of death Hypostatic pneumonia

Due to Burns of both hands & feet

Due to Fracture

Other Conditions Chronic Hypertension
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home or place)
(e) Means of injury
23. Signature Ellwood Wolfe
Address Provident Hosp Date signed 1/18/49

VS 150

190

0505 B.C.48-28644 ✓ G70505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

Registered No.

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 18 (If outside city or town limits, write RURAL and give town)
12-2 (d) Street No. 3119 N. Calvert st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Reedy
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Newborn

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/31/48

8. AGE: Years	Months	Days	If less than one day
			1 hr. 50 min.

9. Birthplace Baltimore-1, Maryland (Town, county, and state)
10. Usual Occupation newborn
11. Industry or business

FATHER
12. Name Herbert Morgan Reedy, Jr.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Alice Bonsal Wylie
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery [redacted] JAN 7 1949
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 14 1949 (Date rec'd by registrar) (b) [redacted]

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1948, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31 1948 to 12-31 1948, and that I last saw him alive on 12-31 1948.

Immediate cause of death Erythroblastosis	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Lovejoy Jr. M. D.
Address University Md. Hosp. Date signed 12-31-48

VS 183

70506 B.C. 48-28067

BALTIMORE CITY HEALTH DEPARTMENT ✓ G70506

CERTIFICATE OF DEATH 160a

Registered No.

PLEASE WRITE PLAINLY, WITH INK. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
21-2
(d) Street No. 815 W. Oxtend St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Pillman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1948

8. AGE: Years	Months	Days	If less than one day
—	—	2	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Harvey B. Pillman
13. Birthplace N.C.

MOTHER
14. Maiden Name Elizabeth Covington
15. Birthplace N.C.

16 (a) Informant Sister of Mother
(b) Address ?

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 7 1949
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) JAN 1 4 1949 (Date rec'd by Registrar) (Signature) Wm. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30/1948, at 4:19 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30/1948 to 12/30/1948 and that I last saw him alive on 12/30/1948.

Immediate cause of death Respiratory and cardiac failure

Due to Cerebral hemorrhage?

Due to Cerebral birth trauma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. J. Rausch M.D.
Address University Hosp. Date signed 12/31/48

VS 150

670507

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

002 Registered No. 670507

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 580 W. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 580 W Preston St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Vera Marshall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age 19 9 years

7. Birth date of deceased (mo., day, yr.) Apr. 1, 1929

8. AGE: Years	Months	Days	If less than one day
29	9	9	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business

FATHER
12. Name Daniel Marshall
13. Birthplace Md.

MOTHER
14. Maiden Name Elnora Bell
15 Birthplace 226 N. Pine St

16 (a) Informant Elnora Marshall
(b) Address 226 N. Pine St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan 14 1949 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Halstead

18 (a) Funeral director
(b) Address 917 Druid Hill Ave

19 (a) JAN 14 1949 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1949, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1949 to Jan 10 1949 and that I last saw her alive on Jan 8 1949.

Immediate cause of death Tuberculosis of Lungs — Duration 1 yr.?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. William Frey M. D.
Address 728 Penna Ave Date signed 1/10/49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

13B

BIRTH NO. 570508 M. 129749

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

002 Registered No. 570508

1. NAME OF DECEASED (Type or Print): Arcilia Bassil

2. DATE OF DEATH: January 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1702 Brentwood Ave. 12-5

5. SEX: F
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 19, 1920
9. AGE (In years last birthday): 28 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Bassil (D)
14. MOTHER'S MAIDEN NAME: Grace Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Baltimore City Hospitals 4940 Eastern Ave. ADDRESS: Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Far Advanced Pulmonary Tuberculosis	1 year
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 1-10, 1949 *to* 1-13, 1949 *that I last saw the deceased alive on* 1-13, 1949 *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Margaret A. Morgan M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 1-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 1/17/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Cedar Hill Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead — ADDRESS: 918 Hillsdale Ave. 1313

VS 150

PLEASE WRITE LEGIBLY. Physician: please write the cause of death clearly and correct age is especially important.

G70609 ✓143 G70609

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Robert Howard

2. DATE OF DEATH: Jan. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 867 W. Lexington St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 867 W. Lexington St. 18-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Feb. 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Baltimore	U. S.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			M's Mertice Howard - 867 W.	Lexington St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

(B) Hypertensive C-V Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/28, 1948 *to* 1/11, 1949 *that I last saw the deceased alive on* 1/11, 1949 *and that death occurred at* 7 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Carter Grant M. D.	601 N. Carrollton	1/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-15-49	Mt. Auburn Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 14 1949	Lurington Williams, M.D.	M's Frances A. Hemsley	578 W. Biddle St.

VS 150

92D

PLEASE WRITE PLAINLY. Physician please write the cause of death clearly and fully. Be sure to complete age is especially important.

G70510 ✓ 490 G70510

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Foster Jacobs

2. DATE OF DEATH: 1-11-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-1
D. STREET ADDRESS (If rural, give location): 5 North Amity Str.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored	Married	Aug. 23, 1925	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer	Refrigeration Helper	North Carolina	US

13. FATHER'S NAME: Theat Jacobs -

14. MOTHER'S MAIDEN NAME: Rachel Perry -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): World War II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elsie - Wife - ADDRESS: 5 N. Amity

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, lobar bilateral — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-11, 1949 *to* 1-11, 1949 *that I last saw the deceased alive on* 1-11, 1949 *and that death occurred at* 11 59/74 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Evans M. D.	University Hosp	1-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	1/14/49	Bur gan	North Carolina

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 14 1949	~~Evelyn Williams, M~~	Mrs Katie R. Williams	Edmondson Av

VS 150

108

PLEASE WRITE PLAINLY, with pen or pencil. Physician: please write the cause of death clearly and legibly. Be sure that the correct age is especially important.

670511 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

456 670511 Registered No.

1. NAME OF DECEASED (Type or Print): Miss Catherine Farbo

2. DATE OF DEATH: Jan. 12, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital
C. Length of stay in Baltimore: 13 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maryland
D. STREET ADDRESS (If rural, give location): 439 Gay St

5. SEX: F
6. COLOR OR RACE: Italian
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: Oct. 2, 1909
9. AGE (In years last birthday): 39 — If Under 1 Year: Months 3, Days 9 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10B. KIND OF BUSINESS OR INDUSTRY: Tailor Shop
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY?: USA.
13. FATHER'S NAME: Mr. Joseph Farbo
14. MOTHER'S MAIDEN NAME: Marie Umbriaco
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 216-07-8623
17. INFORMANT: Deceased Patient — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lupus Erythematosus — INTERVAL BETWEEN ONSET AND DEATH: 21 yrs
DUE TO
(B)
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) Streptococcus Viridans Septicemia ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 13, 1948 *to* Jan. 12, 1949, *that I last saw the deceased alive on* Jan. 12, 1949, *and that death occurred at* 6:55 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: L. M. Howard M. D.
23B. ADDRESS: Church Home & Hospital
23C. DATE SIGNED: 1/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 15 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair rd. Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Frank Della Rocca — ADDRESS: 322 S. High St.

VS 150

153

G70512

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

143 G70512

Registered No.

1. NAME OF DECEASED (Type or Print): DR. SALVATORE J. DE MARCO

2. DATE OF DEATH: 11 JAN 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL
c. Length of stay in Baltimore: 68 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: (BALTO)
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO # 18
D. STREET ADDRESS (If rural, give location): 12 Charlcote Place 7-11

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 21 AUG 1880
9. AGE (In years last birthday): 68 — If under 1 year: Months 4, Days 21, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Salvatore J. DeMarco
14. MOTHER'S MAIDEN NAME: MARIA JEPPI

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: DR SALVATORE DEMARCO JR. SON — ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CORONARY THROMBOSIS	12 HRS
DUE TO (B)	HYPERTENSIVE HEART DISEASE	5 YRS
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	GENERALIZED ARTERIOSCLEROSIS	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2 AM 11 JAN, 1949, *to* 2 PM 11 JAN, 1949, *that I last saw the deceased alive on* 11 JAN, 1949, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: John A Ferrie M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 11 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 15 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): old Frederick Rd. Balt. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Troull & Dallahoee
ADDRESS: 322 S. High St

VS 150

937

Please write plainly. Physician please write the cause of death clearly and legibly. Cause age is especially important.

70513 B.C. 48-28+29

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. 670513

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 S. Paca St #30 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Moore
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race negro | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-24-48
8. AGE: Years | Months | Days | If less than one day hr. 10 min.
9. Birthplace University Hospital (Town, county, and state)
10. Usual Occupation infant
11. Industry or business

FATHER
12. Name Davis Moore
13. Birthplace Rocky Mt. N.C.

MOTHER
14. Maiden Name Margaret Moore
15. Birthplace Mathis County, Va

16 (a) Informant mother
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 7 1949

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 7 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1948, at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1948 to 12/24 1948 and that I last saw h[illegible] alive on 12-24 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to atelectasis	
Due to	
Other Conditions breech extraction	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James M. Brennan M.D. M. D.
Address Univ. Hosp. Date signed 12-29-48

PLEASE WRITE LEGIBLY, with ON correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

570514 B.C. 48-2946 157.3 Registered No. 570514

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
11-4
(d) Street No. 1222 Madison Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Diane Lynn Bethea

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/31/48

8. AGE: Years	Months	Days	If less than one day
—	—	3	hr. min.

9. Birthplace Baltimore, Md. (town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Cleophus Bethea
13. Birthplace S.C.

MOTHER
14. Maiden Name Jessie Burden
15. Birthplace S.C.

16 (a) Informant Cleophus Bethea
(b) Address 1222 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 7 1949

18 (a) Funeral director
(b) Address Commissioner of Health

19 JAN 1 4 1949 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2/1949 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2/1948 to 1/2/1948 and that I last saw her alive on 1/2/1948.

Immediate cause of death	Duration
Respiratory & Cardiac failure	
Due to Shock	
Due to Uremia (???)	
Other Conditions Congenital anomaly of GU System — Hepatomegaly	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. J. Sheehan Jr. M.D.
Address University Hosp. Date signed 1/2/48

1578

PLEASE WRITE PLAINLY, with pen and ink. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

670515 BALTIMORE CITY HEALTH DEPARTMENT 763.0 670515

BIRTH NO. B.C.49-00647 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Kobylski

2. DATE OF DEATH: 1/13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Church Home & Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

c. Length of stay in Baltimore: Yrs. 36 hours. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1202 Steelton Ave 26-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Single	1/12/49			1	36	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	O	Maryland	U.S.

13. FATHER'S NAME: Richard Kobylski

14. MOTHER'S MAIDEN NAME: Lucille Reed

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: Hospital Record ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-12, 1949 *to* 1-13, 1949 *that I last saw the deceased alive on* 1-13, 1949, *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: T. Lacy Mowbray M. D. | 23B. ADDRESS: Church Home & Hospital | 23C. DATE SIGNED: 14 Jan '49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 24B. DATE: JAN 14 1949 | 24C. NAME OF CEMETERY OR CREMATORY: HOLY REDEEMER | 24D. LOCATION (City, town, or county) (State): 4430 BELAIR RD.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949 | REGISTRAR'S SIGNATURE: Thurlington for Williams, M.D. | 25. FUNERAL DIRECTOR: Duffel Bros ADDRESS: 7110 BELAIR RD.

VS 150

107

G70516 ✓ 434.3 G70516

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Samuel Bagby

2. DATE OF DEATH: 1/12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1422 McCulloh St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1422 McCulloh St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md. 17 14-2
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	W	4/4/1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamin Bagby	Sallie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT — ADDRESS
No		Sarah Bagby 1422 McCulloh St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Organic heart disease — Interval between onset and death: History indefinite

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 1, 1948 *to* Jan 12, 1949, *that I last saw the deceased alive on* Jan 12, 1949, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. Garland Shirell M. D.	1534 Druid Hill Ave	Jan. 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/15/49	Mt Auburn	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 14 1949	Huntington Williams, M.D.	Geo. G. Kelson 1303 Presstman St.

VS 150

95 c

G70517 ✓ 162.0 G70517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.49-00437 Registered No.

1. NAME OF DECEASED (Type or Print): Steven Warren Stevenson
2. DATE OF DEATH: 1-12-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. — Mos. 1 — Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE md; B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-3
D. STREET ADDRESS (If rural, give location): 1922 Ettings, St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)
m	negro	Single	1-11-49	1 day 18 hr 25 min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): h.l Boy carpenter
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Douglas Montague
14. MOTHER'S MAIDEN NAME: Delonia Helena Stevenson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO
17. INFORMANT: Miss Delonia Stevenson — ADDRESS: 1922 Ettings st.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia Livida

DUE TO

(B) Prolonged 2nd Stage

DUE TO

(C) Borderline Pelvis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 11, 1949 *to* Jan 11, 1949 *that I last saw the deceased alive on* Jan 12, 1949, *and that death occurred at* 4.45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edward H Sisler M. D.
23B. ADDRESS: Provident Hosp.
23C. DATE SIGNED: 1/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. H. Kelson
ADDRESS: 1303 Druid Hill Ave

JAN 14 1949

Js 150

161a

Correct age is especially important. Physician must see the body.

H86066

171

G70518 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70518 — Registered No.

1. NAME OF DECEASED (Type or Print): Sarah Cantley

2. DATE OF DEATH: Jan. 13 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1517 Presson Ct. 15-1

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. / Mos. / Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	Negro	Widowed	6—69	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): S. Carolina
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Abram Martin
14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:

17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Cervix c
DUE TO
(B) uremia
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: none

INTERVAL BETWEEN ONSET AND DEATH: unknown

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 10 1949 *to* Jan. 13, 1949 *that I last saw the deceased alive on* Jan. 13, 1949, *and that death occurred at* 10½ *m., from the causes and on the date stated above.*

23A. SIGNATURE: John Watt, Jr., M.D. M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 14 Jan '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR: Geo. G. Kelson
ADDRESS: 1303 Greenmount Ave

VS 150

48a

G70519
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.0

Registered No. G70519

1. NAME OF DECEASED (Type or Print): ANdrew. J. PeTerSON
2. DATE OF DEATH: JAN 12. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1620 Cherry. ST.
C. Length of stay in Baltimore: 40 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: /
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTimore
D. STREET ADDRESS (If rural, give location): 1620 Cherry ST 25-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Nov 23 1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ReTire		bTh.	?

13. FATHER'S NAME: P. J. PeterSON
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—		MADELINA. PeTerSON	1620 Cherry

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia
DUE TO Chronic nephritis
(B) Arterio sclerotic cardiovascular disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Advanced senility

INTERVAL BETWEEN ONSET AND DEATH
(A) 7 days
(B) YEARS
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 11, 1949, to Jan. 12, 1949, *that I last saw the deceased alive on* Jan. 12, 1949, *and that death occurred at* 4:40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sidney R. Gilbert M. D.
23B. ADDRESS: 4700 Pimmington
23C. DATE SIGNED: Jan. 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: Jan 17-1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): Anne Arundel County MD

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph Kasenakes Inc
ADDRESS: 602 Washington Blvd

VS 150

13 1a

Collect age is especially important. Physician: please write the cause of death clearly and legibly.

G70520 — BALTIMORE CITY HEALTH DEPARTMENT — 238 — G70520

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Alfred S. DAY

2. DATE OF DEATH: 13 January 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: 73 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18 12-1
D. STREET ADDRESS (If rural, give location): 3916 Clovehill Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	6-6-75	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred S. Day
14. MOTHER'S MAIDEN NAME: Mary Reeves

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Wife ADDRESS: 3916 Clovehill Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Multiple Myeloma — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 25, 1948 *to* Jan 13, 1949 *that I last saw the deceased alive on* Jan 13, 1949, *and that death occurred at* 12:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Frank Supplee III M. D.
23B. ADDRESS: Union Memorial Hosp
23C. DATE SIGNED: Jan 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 15/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Chestnut Grove, Baltimore
24D. LOCATION (City, town, or county) (State): County, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Stewart & Mowen Co. ADDRESS: 108 W. North Ave.

VS 150

55E

Please write the cause of death very carefully. Physician: please write the cause of death very carefully. Physician: please write the cause of death very carefully. Physician:

G70521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

201

Registered No. G70521

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lonetta Marie Young

2. DATE OF DEATH January 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 26 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 523 Chateau Ave. 27-10

5. SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months. Days	If Under 24 Hours Hours. Min.
Female	White	Single	3-15-22	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Draftsman		Md.	

13. FATHER'S NAME Albert S. Young

14 MOTHER'S MAIDEN NAME Lonetta Prosser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hodgkin's Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-3 1949 *to* 1-12, 1949, *that I last saw the deceased alive on* 1-12, 1949, *and that death occurred at* 9 35 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
John G. Wilkes M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	Jan 17 1949	Lutheran Cemetery, Glendale,	Queens Co., New York

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	Stewart & Mowen Co.,	108 W. North Ave. City #1.

VS 150

44 B

Please write the cause of death clearly and legibly. Physician, please write the cause of death clearly and legibly. Physician, please write the cause of death clearly and legibly. Physician,

G70522

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.1

Registered No. G70522

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Cecelia A. Heiligenstadt

2. DATE OF DEATH: Jan. 13 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4410 Powell Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 26-1
D. STREET ADDRESS (If rural, give location): 4410 Powell Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Sept 29 1873
9. AGE (In years last birthday): 75 — If under 1 year: Months 3, Days 14 — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John J Logue
14. MOTHER'S MAIDEN NAME: Mary A. Reilly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Florence Brenna ADDRESS: 4410 Powell Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocarditis, Arteriosclerotic — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1946, *to* 1/12, 1949 *that I last saw the deceased alive on* 1/6, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: D. J. Battaglia M. D.
23B. ADDRESS: 5829 Belair Rd
23C. DATE SIGNED: 1/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or County) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Temperance Williams, M.D.
25. FUNERAL DIRECTOR: E. J. Feeney & Son
ADDRESS: 1938 E. Lafayette Ave.

937

VS 150

Connect age is especially important. Physician: please write the cause of death clearly and legibly.

M.M. 126019
G70523
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

490

Registered No. G70523

1. NAME OF DECEASED (Type or Print): Arthur Chase

2. DATE OF DEATH: January 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 1914 E. Federal ST. 8-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	White	Married	July 27, 1890	58	5	16		

10A. USUAL OCCUPATION (Give kind of work, even during most of working life if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mold Maker	Printing	Balto. Md.	

13. FATHER'S NAME: George Chase

14. MOTHER'S MAIDEN NAME: Elizabeth O'Neil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Balto. City Hospitals	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Jan 12, 1949, to Jan 13, 1949, that I last saw the deceased alive on Jan 13, 1949, and that death occurred at 7:30 A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Max E. Buchtold M. D.	Balto City Hosp.	Jan 13/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	1/17/49	Holy Redeemer	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 14 1949	Huntington Williams, M.D.	E. J. Fleming & Son	1938 E. Lafayette Ave.

VS 150

108

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H25.0 ✓ H43

G70524

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Mary Stacharowski

2. DATE OF DEATH: Jan 13th, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2515 Foster Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

C. Length of stay in Baltimore: 59yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24
D. STREET ADDRESS (If rural, give location): 2515 Foster Ave

1-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	White	Widow	Oct, 15-1873	75	2	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Poland	

13. FATHER'S NAME: Thomas Jankowiak

14. MOTHER'S MAIDEN NAME: Mary Wawrzyniak

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	220-03-9536	Miss. Frances Stacharowski	2515 Foster Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Cerebral Hemorrhage — 12/21/48

DUE TO

(C) Arteriosclerotic, Hypertensive Cardio-Vascular Disease — 6 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 26, 1943 *to* Jan 13, 1949, *that I last saw the deceased alive on* Jan 13, 1949, *and that death occurred at* 11:05 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph F. Arenga, M. D.	209 W. Lanvale St	1/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan-17-1949	St. Stanislaus	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 14 1949	Huntington Williams, M.D.	George A. Weber	705 South Ann Street

VS 150

937

Correct age is especially important. Physician: please write the cause of death in plain language.

G70525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.0

Registered No. G70525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be correctly given. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. CARROLLTON AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
16-1
(d) Street No. 822 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH TILGHMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1873

8. AGE: Years	Months	Days	If less than one day
75	-	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James H. Tilghman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Paraway
15. Birthplace Md.

16 (a) Informant John G. Tilghman
(b) Address 2305 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-49 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 14 1949 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13 1949, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 1948 to 1-9 1949 and that I last saw h. IM. alive on JAN. 9, 1949.

Immediate cause of death	Duration
ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	?
Due to: GENERALIZED ARTERIOSCLEROSIS	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address 1824 W. Franklin St Date signed 1-13-49

VS 150

93D

670526

BALTIMORE CITY HEALTH DEPARTMENT 443 Registered No. 670526

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. CARROLLTON AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
16-1 (d) Street No. 822 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSA B. DENT.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1872

8. AGE: Years	Months	Days	If less than one day
77	-	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Samuel Ross
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Miss Rose Steward
(b) Address 822 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-49 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 1 1949 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 13 1949 at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1948 to 1-13 1949 and that I last saw her alive on 1-3 1949.

	Duration
Immediate cause of death HYPERTENSIVE CARDIO-VASCULAR DISEASE	2
Due to GENERAL HYPERTENSION	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address R 24 W FRANKLIN (Date signed 1-13-49

937

VS 180

G70527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 47 G70527
N-477.8

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CATHERINE JONES

2. DATE OF DEATH: January 13, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 103 West Monument Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 103 West Monument Street 11-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
Female	White	Divorced	Feb. 18, 1912	36	10	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secretary	Doctor's Office	New York	

13. FATHER'S NAME: John T. Nablo

14. MOTHER'S MAIDEN NAME: Kathryn Hering

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Mr. John L. Nablo New York

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Barbiturate poisoning (seconal)
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Acute alcoholism
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	103 West Madison Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
1 13 48 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Ingestion of sleeping tablets

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George L. Merrill M.D.		1/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	1 14 49	Greenmount	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 14 1949	Huntington Williams, M.D.	Wm. Cook Inc. 1217 St. Paul St

179 B

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G70528 ✓ 16 | G70528

BIRTH NO. G70528

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Elizabeth Magill

2. DATE OF DEATH: 1-12-49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3027 Eastern Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3027 Eastern Ave 1-2

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	10-22-1887	61	2	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Balto. Md.	

13. FATHER'S NAME: John Ackerman

14. MOTHER'S MAIDEN NAME: Margaret Wiegand

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Fred Magill ADDRESS: 3027 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of the Stomach	2 yrs
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov 19, 1948	Carcinoma of Stomach + generalized metastases	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 14, 1948 *to* 1/12, 1949 *that I last saw the deceased alive on* 1/12, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. J. Battaglia M. D.	5829 Belair Rd	1/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-15-49	Moreland Park	Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
	Contingent for Williams, M.D.	Wm Cook Inc. 1217 St. Paul St.

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46 B

G70529 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

151 Registered No. G70529

1. NAME OF DECEASED (Type or Print): George W. Gomolka
2. DATE OF DEATH: Jan 12-1949
3. PLACE OF DEATH: a. Baltimore City, Maryland 3108 Clearview
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 35 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Marryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3108 Clearview Ave 27-5
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1882
9. AGE (In years last birthday): 67 66 If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Consolidated Eng
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Thomas Gomolka
14. MOTHER'S MAIDEN NAME: anna
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-14-5057
17. INFORMANT: Anna Gomolka ADDRESS 3108 Clearview ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 12 1948 to Jan 12, 1949 that I last saw the deceased alive on Jan 12, 1949 and that death occurred at 5.45 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Anthony Kwiatkowski M. D.
23B. ADDRESS: 3024 Eastern Ave
23C. DATE SIGNED: 1/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Baltimore, Md. 1/13/49

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William S. Fialkowski ADDRESS: 2007 Eastern Ave.

VS 150

46 B

Please write the cause of death in English. Physician... important. Correct age is especially important.

G70530 X 171 G70530

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): EDNA L. NORRIS - Edna L.

2. DATE OF DEATH: 1/12/45 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital

C. Length of stay in Baltimore: Life? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27 Lauraverton
D. STREET ADDRESS (If rural, give location): 5203 Carroll Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W	22 Sept 1898	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Schmoller-Peerata
10B. KIND OF BUSINESS OR INDUSTRY: Filing Clerk
11. BIRTHPLACE (State or foreign country): Maryland ?
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: William H. Steinweder
14. MOTHER'S MAIDEN NAME: Estelle Woody

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): unknown (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: 220-24-1541
17. INFORMANT: Patient ADDRESS:

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure.
DUE TO
(B) Widespread metastases
DUE TO
(C) Carcinoma - Cervix uteri grade III (a+top.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cachexia

INTERVAL BETWEEN ONSET AND DEATH: Apr 1945 - Jan 1949.

19A. DATE OF OPERATION: 7 Sept '45
19B. MAJOR FINDINGS OF OPERATION: Spread of Ca thru pelvic tissues & vessels.
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 22 Dec 1948 *to* 12 Jan 1949, *that I last saw the deceased alive on* 11 Jan 1949, *and that death occurred at* 1 10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jesse R Maxwell M. D.
23B. ADDRESS: St Agnes Hospital
23C. DATE SIGNED: 1/12/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 15 Jan 49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. F. Wippert & Son ADDRESS: 800 Eutaw Pl

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G70531 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70531

1. NAME OF DECEASED (Type or Print): Agnes M. Giering
2. DATE OF DEATH: 1/12/49
3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3906 Parkside Drive
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-1; D. STREET ADDRESS (If rural, give location): 3906 Parkside Drive
5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 2/5/77
9. AGE (In years last birthday): 71 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Wm Schutter
14. MOTHER'S MAIDEN NAME: Mary Owens
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Dr. Herman J. Giering — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1935 *to* Jan 4, 1949 *that I last saw the deceased alive on* Jan 4, 1949, *and that death occurred at* 11:30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Herman Giering M. D.
23B. ADDRESS: #316 Med. arts Bldg
23C. DATE SIGNED: Jan 12, 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/15/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): End of East North Ave

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Lilly + Zeiler - 403 S. Wolfe St.

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G70532 BALTIMORE CITY HEALTH DEPARTMENT 442 G70532
Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, with ink. Use typewriter if possible. Do not abbreviate. Give full name of deceased. If not in hospital or institution, give residence. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3316 Liberty Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
3316 Liberty Hgts Ave
(a) State (b) County
(c) City or town Baltimore 15. Md
(If outside city or town limits, write RURAL and give town)
15-11
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Louise Justis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single.

6 (b) Name of husband or wife --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 5. 1869

8. AGE: Years	Months	Days	If less than one day
79	3	8	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER 12. Name	John C.C. Justis
FATHER 13. Birthplace	Baltimore, Md
MOTHER 14. Maiden Name	Louisa M Lewis
MOTHER 15. Birthplace	Frka. Pa.

16 (a) Informant Margaret K Doyle
(b) Address 3316 Liberty Hgts Ave
17 (a) Burial (b) Date thereof 1/15/49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Burial
Location Greenmount Cem.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
JAN 14 1949 (b) Lexington Hill
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-13 1949, at 8.55 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1931, to Jan 1949
and that I last saw h[illegible] alive on Jan 12 1949.
Immediate cause of death

	Duration
Diabetes mellitus	
Due to Cardio-vascular renal disease c. Hypertension	
Due to Old age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles F. Warner M. D.
Address 421 Med. Arts Bldg signed 1/13/49
Baltimore, Md 61

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BIRTH NO. G70533

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 442 42040 G70533 Registered No.

1. NAME OF DECEASED (Type or Print): EDITH McLEAN ANDERSON
2. DATE OF DEATH: Jan. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2126 N. Smallwood St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2126 N. Smallwood St. 15-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Sept. 19, 1875	73 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	May Co.	Baltimore, Md.	

13. FATHER'S NAME: Thomas E. Foster, Sr.
14. MOTHER'S MAIDEN NAME: Jane McLean

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT
no		son Mr. C. Lee Anderson ADDRESS Wood St. 2126 N. Small-

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic & hypertensive cardiovascular renal disease

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1947 *to* Jan, 1949 *that I last saw the deceased alive on* Jan 13, 1949 *and that death occurred at* 4:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: I. Shorofsky M.D. M. D.
23B. ADDRESS: 601 N. Monroe St.
23C. DATE SIGNED: 1/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md

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G70534

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 G70534

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): John Dittmar, Jr.

2. DATE OF DEATH: Jan. 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp.

c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1718 E. 33rd St. 9-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	July 14, 1875	73 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): President

10B. KIND OF BUSINESS OR INDUSTRY: John Dittmar & Sons Inc.

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Dittmar

14. MOTHER'S MAIDEN NAME: Barbara Hefferbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 217-09-3977

17. INFORMANT: Mrs. Catherine K. Dittmar ADDRESS: 1718 E. 33rd St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Cardio-Vascular Hypertension — 10 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-12, 1949, *to* 1-13, 1949, *that I last saw the deceased alive on* 1-13, 1949, *and that death occurred at* 5:10A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard C. Hayden M. D.

23B. ADDRESS: Bon Secours Hosp.

23C. DATE SIGNED: 1-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 15, 1949

24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949

REGISTRAR'S SIGNATURE: Lillington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

92D

G70535 BALTIMORE CITY HEALTH DEPARTMENT G70535

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE SCHLAG

2. DATE OF DEATH: Jan. 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3333 Edmondson Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3333 Edmondson Ave. 20-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widowed	March 27, 1860	88 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. Anna S. Parsons ADDRESS: 3333 Edmondson Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Thrombosis	1/13/49
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Arteriosclerotic C.V. Disease	10+ yrs
	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* JAN 1938 *to* 1/13 1949, *that I last saw the deceased alive on* 1/12 1949, *and that death occurred at* 9 55 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 3629 Edmondson Ave., Balto

23C. DATE SIGNED: 1/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/17/49	Lorraine Cem.	Woodlawn, Md,

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949

REGISTRAR'S SIGNATURE: [signature]

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

93D

G70536 ✓420.0 G70536

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ELLEN EMERSON WHITESTONE

2. DATE OF DEATH: Jan. 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5221 Reisterstown Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 5221 Reisterstown Rd. 27-18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widow	July 18, 1865	83 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Culpeper, Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bernard Rosson

14. MOTHER'S MAIDEN NAME: Alvia Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT: Mrs. C. A. Coleman ADDRESS: 5221 Reisterstown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	- Arterio - Sclerotic Heart Disease	5 yrs.?
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)	Generalized Arterio Sclerosis	5 yrs.?
DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION: —

20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 29, 1946, *to* Jan. 13, 1949, *that I last saw the deceased alive on* Jan. 13, 1949, *and that death occurred at* 4.30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Earl L. Chambers, M. D.

23B. ADDRESS: 4108 Liberty Hts. Ave.

23C. DATE SIGNED: 1/14/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 1/16/49

24C. NAME OF CEMETERY OR CREMATORY: Fair View Cem.

24D. LOCATION (City, town, or county) (State): Culpeper, Va.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949

REGISTRAR'S SIGNATURE: [illegible] Registrar, Baltimore, Md.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

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670537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1 ✓

Registered No. 670537

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH MACIS

2. DATE OF DEATH Jan. 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 714 W. Lombard St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore Yrs. thirty five years Mos.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 637 W. Pratt st. 22-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	White	SINGLE	March 19, 1893	55	10			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TAILOR	COAT MAKER	LITHUANIA	U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	NO	216-01-7610-A	Edward Macis	423 N. Exeter St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis

(B) Myocardial infarction

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* _____ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		Jan. 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/15/49	Most Holy Redeemer	Belair Road Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 14 1949	Huntington Williams, M.D.	Geo. W. Jackson	703 McHenry St

correct age is especially important. Physician: please write the cause of death in plain English.

VS 151

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H 2H 4W

G70538 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ X 571.0 G70538

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Herbert McKinley Brooks

2. DATE OF DEATH: JAN 14 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 4 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Calvert
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Huntingtonon
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 8.29.48
9. AGE (In years last birthday): If Under 1 Year: Months 4, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME: John R. Brooks
14. MOTHER'S MAIDEN NAME: Annie Tyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — Interval between onset and death: 2

DUE TO

(B) Dehydration — Interval between onset and death: 3

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Diarrhea - pneumonia — Interval between onset and death: 5

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-11-1949 *to* 1-14-1949 *that I last saw the deceased alive on* 1-14-1949 *and that death occurred at* 5:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. C. Long, M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Patapsco
24D. LOCATION (City, town, or county) (State): Calvert co Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1949 JAN 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: ADDRESS: P. E. Sewell Prince Frederick

11 9a

collect age is especially important. Physicians, please write clearly

G70539 ✓ 085.1 G70539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. BC-48-07398 Registered No.

1. NAME OF DECEASED (Type or Print): William H. Fink III

2. DATE OF DEATH: Jan. 14 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1026 Briscoe St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1026 Briscoe St. 21-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single - Child	April 1 1948		9	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Maryland	

13. FATHER'S NAME: William H. Fink

14. MOTHER'S MAIDEN NAME: Catherine Bauer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		William H. Fink - 1026 Briscoe St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Measles — 5 DAYS

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 13 Jan 49 *to* 14 Jan 49, *that I last saw the deceased alive on* 12 Jan 49 *and that death occurred at* 8:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward D'Arcy Dillon M.D. M. D.	682 N Washington Blvd	14 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-15-49	Glen Haven	Ritchie Highway - Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 15 1949	Huntington Williams, M.D.	Wm. Cook Inc. 1217 St. Paul St.

VS 150

25

6-0540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1 Registered No. 6-0540

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Roger & Dukeland St.
(c) Hospital or institution:
West Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) ~~City~~ or town Chasa Co Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Pa
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Paul Schmidt Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-4435

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife Louise Schmidt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, ~~yr~~) April 18th 1890

8. AGE: Years	Months	Days	If less than one day
58	8	26	hr. min.

9. Birthplace California
(Town, county, and state)

10. Usual Occupation Air Conditioning Mechanic

11. Industry or business Md. Refrigeration Co

FATHER
12. Name John P. Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Kesselring
15. Birthplace Germany

16 (a) Informant Franklin N. Schmidt
(b) Address 4400 Patapsco Ave. Chesapeake Park

17 (a) Burial (b) Date thereof 1/17/49
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 15 1949 Huntington Williams
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14/49 at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11/49 to 1/14/49.
and that I last saw him alive on 1/14 1949.

Immediate cause of death Cardiac failure — Duration

Due to Coronary arteriosclerosis

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Paul Young M.D.
Address U.B.C. Hospital Date signed 1/14/49

94a

VS 190

G70541

BALTIMORE CITY HEALTH DEPARTMENT 177

CERTIFICATE OF DEATH

Registered No. G70541

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Berwick Ave #16 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Floyd Hanson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. Floyd Hanson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4th 1893

8. AGE: Years	Months	Days	If less than one day
55	2	10	hr. min.

9. Birthplace Pa. (Town, county and state)
10. Usual Occupation Retired - Technician
11. Industry or business Western Electric Co.

FATHER
12. Name Stephan Hanson
13. Birthplace England

MOTHER
14. Maiden Name Ada Brost
15. Birthplace Pa.

16 (a) Informant Mrs Belle Hanson
(b) Address 2910 Berwick Ave
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 15- 1949 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Akron
Location Ohio
18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St. Paul
19 (a) JAN 15 1949 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14/49 19 , at 12 50 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1949 to 1/14 1949
and that I last saw him alive on 1/14 1949

Immediate cause of death
Uremia
Due to Carcinoma of prostate
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Arlyn H. Wood M. D.
Address West Baltimore General Hosp Date signed 1/14/49

VS 150

51B

G70542 410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70542

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. HELEN H SIMMONS

2. DATE OF DEATH: 14 JAN 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GEN. HOSP.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 27-10
D. STREET ADDRESS (If rural, give location): 4702 Old York Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	MARRIED	20 SEPT 1894	54 57	3 24	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary X HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: Fidelity Real Estate Co
11. BIRTHPLACE (State or foreign country): Post Deposit
12. CITIZEN OF WHAT COUNTRY? Md.

13. FATHER'S NAME: John A Hohn
14. MOTHER'S MAIDEN NAME: Lettie Hurlock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SUBACUTE BACTERIAL ENDOCARDITIS (AORTIC VALVE) — INTERVAL BETWEEN ONSET AND DEATH: 1 MONTH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) RHEUMATIC HEART DISEASE WITH MITRAL & AORTIC VALVULITIS — 25 YRS

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

SUBSTERNAL THYROID
FIBRINOUS PERICARDITIS, ACUTE

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES X NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 31 DEC, 1948 *to* 14 JAN, 1949 *that I last saw the deceased alive on* 14 JAN, 1949 *and that death occurred at* 9:05 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald L. England M. D.	Maryland Gen. Hosp.	14 Jan 49

24A. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY OR ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	1-17-49	Hopewell	Post Deposit Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 15 1949	Huntington Williams M.D.	W. Cook Inc. 1217 St. Paul St.

VS 150

92c

correct age is especially important. Payment

Niedzielski ✓ 422.2

G70543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70543

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Agnes Niedzielski

2. DATE OF DEATH: Jan. 12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 119 S. Castel St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days 2-1

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
119 S Castel St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore Md
D. STREET ADDRESS (If rural, give location)
119 S Castel St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 1889
9. AGE (In years last birthday): 60 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Toporek
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Edward Niedzielski 119 S Castel St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) Cerebral apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(b) Cerebral arterio-sclerosis Chronic Myocardial Insuff. — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(c)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 4 '49 to Jan. 12 '49 that I last saw the deceased alive on Jan. 12 1949, and that death occurred at 11 P. m., from the causes and on the date stated above.

23A. SIGNATURE: Emerson Bengloe M. D.
23B. ADDRESS: 200 E. Pratt St
23C. DATE SIGNED: 1/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 17/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Fred W. Ozazewski
ADDRESS: 930 Eastern Ave.

VS 150

83a

Correct age is especially important. Figures must be given.

✓ 420.1

G70544 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70544 — Registered No.

1. NAME OF DECEASED (Type or Print): LEON LAUER.

2. DATE OF DEATH: 1/14/49.

3. PLACE OF DEATH: A. Baltimore City, Maryland — Emersonian Apts.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 66 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Emersonian Apts. 13-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Married	Mch.15,1882.	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Real Estate
10B. KIND OF BUSINESS OR INDUSTRY: Dealer
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Solomon Lauer
14. MOTHER'S MAIDEN NAME: Delia Oettinger.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Mrs. Mildred O.Lauer:Emersonian Apts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis: myocardial infarct. — INTERVAL BETWEEN ONSET AND DEATH: 10 hours.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary artery sclerosis: angina pectoris — 14 yrs 9 mos
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Generalized arteriosclerosis } " "
Moderate hypertension }

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 2d, 1934 *to* Jany 14, 1949 *that I last saw the deceased alive on* Jany 14, 1949, *and that death occurred at* 1.30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis C. Hamburger M. D.
23B. ADDRESS: 1207 Eutaw Place.
23C. DATE SIGNED: 1/14/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan.16,1949
24C. NAME OF CEMETERY OR CREMATORY: Har Sinai Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 15 1949
REGISTRAR'S SIGNATURE: Tunstall Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: David Samos Sons & Son, 1902 Eutaw Place.

VS 150

94a

G70545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

154.0

G70545

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Michael Rosen

2. DATE OF DEATH January 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 2 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE N. Y.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Far Rockaway
D. STREET ADDRESS (If rural, give location) 310 Central Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	White	Child	3-17-45	3 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	—	N. Y.	U. S.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	None		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Heart disease (Tetralogy of Fallot.

DUE TO (B) Pulmonary Edema

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-12, 1949 *to* 1-14, 1949 *that I last saw the deceased alive on* 1-14, 1949, *and that death occurred at* 6 50 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. H. Mueller M. D.	JOHNS HOPKINS HOSPITAL	1/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1/15/49.	Cedar Park	Emerson, N. J.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 15 1949	Timothy Thos. Williams, M.D.	David Goodheim & Son	1902 Eastern Ave

VS 150

157E

Rev.—2-19-29—L. P. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

331

G70546

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Washington Apts. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Franklin Bratney

(a) RESIDENCE NO. Washington Apts ST., 11-2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	White	SINGLE

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) OCT. 22, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) A.T.T. Co.

(c) Name of employer A.T.T. Co.

9 BIRTHPLACE (city or town) St. Louis
(State or country) Missouri

PARENTS

10 NAME OF FATHER Theodore S. Bratney

11 BIRTHPLACE OF FATHER (city or town) Preston
(State or country) Illinois

12 MAIDEN NAME OF MOTHER Sara Mitchel

13 BIRTHPLACE OF MOTHER (city or town) Preston
(State or country) Illinois

14 Informant J. F. Bratney
(Address) Leesburg Va.

15 Filed JAN 15 1949 19 Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15, 1949

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1949 to Jan 14 1949
that I last saw him alive on Jan. 14, 1949
and that death occurred, on the date stated above, at 6 45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) John H. Trescher M. D.

1/15 1949 (Address) 1032 Dr. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Cemetery Leesburg Va.

DATE OF BURIAL 1/16 1949

20 UNDERTAKER John O. Mitchell & Sons

ADDRESS 832 Baltimore Md.

✓ 420.1

G70547

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70547

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Maria Bawroski

2. DATE OF DEATH: Jan 13 - 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 1608 Church St
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

c. Length of stay in Baltimore: 39 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1608 Church St 25-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Dec. 26-1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): austria
12. CITIZEN OF WHAT COUNTRY? austria
13. FATHER'S NAME: antoni Koc
14. MOTHER'S MAIDEN NAME: —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Peter Bawroski ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.
DUE TO
(B) Coronary thrombosis — 3 mo.
DUE TO
(C) Arteriosclerotic C.V. disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 20, 1948 *to* Jan. 13, 1949, *that I last saw the deceased alive on* Jan. 12, 1949, *and that death occurred at* 2:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sidney R. Gehlert M. D.
23B. ADDRESS: 4700 Penna Ave.
23C. DATE SIGNED: Jan. 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 17-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross AA Co
24D. LOCATION (City, town, or county) (State): A. A. Co.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. S. Fialkowski ADDRESS: 3007 Eastern ave

VS 150

61

G70548 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E974.0 ✓ Registered No. 1991. G70548

1. NAME OF DECEASED (Type or Print): EDMUND JACOBS

2. DATE OF DEATH: January 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2237 East Oliver Street 8-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
male	white	Married	April 9 1902	46	9	5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Drugs Exp Co
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John L. Jacobs
14. MOTHER'S MAIDEN NAME: Ella Rooney
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Helen V. Jacobs ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Asphyxiation by hanging.	
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2237 East Oliver Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 14 49 ? m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hanging from cellar rafter

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: January 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-17-49
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, county) (State): Frederick Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 15 1949
REGISTRAR'S SIGNATURE: Tunstington Williams, M.D.
25. FUNERAL DIRECTOR: John C. Miller Inc. ADDRESS: 164a

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G70549 ✓ 420.1 G70549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John H. Markland

2. DATE OF DEATH Jan-12-1949

3. PLACE OF DEATH: A. Baltimore City Maryland 2407 E. Chase St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2407 E. Chase St. 8-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Widowed	March-20-1865	83	9	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto. Md.	

13. FATHER'S NAME William Thomas Markland

14. MOTHER'S MAIDEN NAME Mary E. Cole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		George Markland	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Thrombosis	sudden
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Arteriosclerotic C.V. Disease	10 yrs.
	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/6, 1941, *to* 1/13, 1949 *that I last saw the deceased alive on* 1/12, 1949 *and that death occurred at* 6:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Karl Grossman M. D.	1212 N. Patterson Park Ave	1/15 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan-19-49	Baltimore	North Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 15 1949	Wellington Williams, M.D.	John C. Milby Sons.	

VS 150

937

770550 BALTIMORE CITY HEALTH DEPARTMENT G770550

CERTIFICATE OF DEATH

E 970.0 N 974.0

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALFRED C. SWENSON

2. DATE OF DEATH: January 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 1 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-1
D. STREET ADDRESS (If rural, give location): 1001 St. Paul Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	June 17, 1907	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer Draftsman

10B. KIND OF BUSINESS OR INDUSTRY: Construction Thompson Grace May

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Swendon

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): World War II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Synthia Swenson ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Butisol Sodium Poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1001 St. Paul Street

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: January 4, 1949 m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Ingestion of Sleeping Tablets

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L Rayer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 1-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: JAN 17 49

24C. NAME OF CEMETERY OR CREMATORY: BALTIMORE NATIONAL

24D. LOCATION (City, town, or county) (State): FREDERICK RD MD

DATE RECEIVED BY LOCAL REGISTRAR: JAN 15 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Duffel Bros. ADDRESS: 710 Belair Rd.

VS 151

1636

G70551 331 G70551

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Sylvia Scott
2. DATE OF DEATH: 1/14/49
3. PLACE OF DEATH: A. Baltimore City, Maryland 1104 Linden Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 10 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1104 Linden Ave 11-4
5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH
9. AGE (In years last birthday): 60 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Mississpi
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Helsey Polk
14. MOTHER'S MAIDEN NAME: ? Parker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Willard Milton ✕ ADDRESS: 312 Huffman St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 5, 1949, *to* Jan 13, 1949 *that I last saw the deceased alive on* Jan 13, 1949, *and that death occurred at* 1 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. Garland Worrell M. D.
23B. ADDRESS: 1534 - Druid Hill Ave
23C. DATE SIGNED: Jan. 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR: 1/15/49
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: William A Jackson ADDRESS: 916 Pennsylvania Ave

VS 150

83a

Certificate Corrected 1-17-49 ✓ 443 670552

552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth M. Say

2. DATE OF DEATH: Jan. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1810 E. 28th St. 9-6 ✓

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Dec. 4, (1886) 1883
9. AGE (In years last birthday): 65 (62) yrs. | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Edmonds
14. MOTHER'S MAIDEN NAME: Catherine Schellhase

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. Joseph I. Say
ADDRESS: 1810 E. 28th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) cerebral thrombosis
DUE TO
(B) Hypertensive Cardio vascular Disease
DUE TO
(C) Bronchopneumonia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 7 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 14 19 49 *to* Jan 14, 1949, *that I last saw the deceased alive on* Jan 14, 1949, *and that death occurred at* 5 25 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Betty May Young M. D. M. D.
23B. ADDRESS: Maryland General Hospital
23C. DATE SIGNED: Jan 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1.18.49
24C. NAME OF CEMETERY OR CREMATORY: Western Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

937

Correct age is especially important. Physicians please write plainly.

70553 ✓ +20.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 670553

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GILBERT J. LESTER

2. DATE OF DEATH: January 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: 22 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-5
D. STREET ADDRESS (If rural, give location): 2580 Edmondson Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Nov. 13, 1880	68 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Insurance Agt.	Balto. Life Ins. Co.	England	

13. FATHER'S NAME: William J. Lester

14. MOTHER'S MAIDEN NAME: Sarah Ann Brooke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	215-01-1582	Mrs. Anna A. Lester	2580 Edmondson Av

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) A.S.C.V.D. (Arteriosclerotic cardiovascular disease)	
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* _____ (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Carl L. Voglum M.D.		January 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/17/49	Meadowridge Mem. Pk.	Howard Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 15 1949	Temporary for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 151

93D

Correct age is especially important. Physicians, please write plainly and use ink.

G70554 ✓ 420.1 G70554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CECIL GRAVATT

2. DATE OF DEATH January 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital

c. Length of stay in Baltimore 27 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-47
D. STREET ADDRESS (If rural, give location) 2510 Poplar Avenue (Drive)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	May 22 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	American Stores	Virginia	

13. FATHER'S NAME
Thomas Gravatt

14. MOTHER'S MAIDEN NAME
Sarah H Gouldman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	World War 1		Olive R. Gravatt	2510 Poplar Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Autopsy, Inspection or Inquiry *Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE George L. Merrill M.D. | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED Jan. 14. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 17 1949	Meadowridge Cem	Washington Blvd Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 15 1949	Huntington Williams, M.D.	Harry H. Truscott	4204 Ridgewood Ave

VS 151

94a

G70555 BALTIMORE CITY HEALTH DEPARTMENT 020.2 G70555

BIRTH NO. B.C.-11622 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): William Foster

2. DATE OF DEATH: 1/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
c. Length of stay in Baltimore: Yrs. Sick Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1728 Orleans St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location) 6-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	Single	May 21-1948		7	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
none	none	Balto City	U.S.a

13. FATHER'S NAME: Joe ?

14. MOTHER'S MAIDEN NAME: Margaret Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Margaret Anderson ADDRESS: 1728 Orleans St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital Lues
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Emil L Sauer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 9 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 15-1949	Mt Calvary Cem	A A Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 15 1949	Huntington Williams M.D.	Robert Williams	1515 McCulloh

VS 151

30F 1515 McCulloh St

670 556 ✓ 151 670 556

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ABRAHAM SAMLER

2. DATE OF DEATH: 1/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL
c. Length of stay in Baltimore: Yrs. 15 Mos. 12 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2806 Suffolk Ave

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 10-15-1890
9. AGE (In years last birthday): 58 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Helper
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William B. Samler
14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Dorothe Samler ADDRESS: 2806 Suffolk Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach
DUE TO
with
(B) Uremia & Peritonitis
DUE TO
(C) Post operative Gastrectomy

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pneumonitis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1/11/49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Stomach
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/6 *19*49 *to* 1/15, *19*49 *that I last saw the deceased alive on* 1/15, *19*49, *and that death occurred at* 2 45 *A*m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harold Susman M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 1/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-16-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 15 1949
REGISTRAR'S SIGNATURE: Transcription for Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Place

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772.0 ✓

G70557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70557

Registered No.

BIRTH NO. B.C. 48-15820

1. NAME OF DECEASED (Type or Print): Philip Schugam

2. DATE OF DEATH: 1-14-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-1
D. STREET ADDRESS (If rural, give location): 4911 Haddow Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	White	Single	6-25-48		6			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alvin Schugam
14. MOTHER'S MAIDEN NAME: Naomie Jaffe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Alvin Schugam — ADDRESS: 4911 Haddow Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Profound inanition	6 mo.
DUE TO		
(B)	carbohydrate intolerance	6 mo.
DUE TO		
(C)		
	cardiac failure	1 day

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Octob 1948, *to* 14 January, 19 49, *that I last saw the deceased alive on* 14 January 1949, *and that death occurred at* 2:55 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: William V. Gross, Jr. M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 14 January 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-16-49
24C. NAME OF CEMETERY OR CREMATORY: Ohel Sholom
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

161 C

G70558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

190 G70558 Registered No.

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3124 E BALTIMORE ST.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3124 E. BALTIMORE ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

6-1

3 (a) FULL NAME George John Seippel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Marr-

6 (b) Name of husband or wife Loretta Seippel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 11, 1874

8. AGE: Years	Months	Days	If less than one day
74	6	4	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business City of Balto

FATHER 12. Name Jacob Seipple

13. Birthplace Germany

MOTHER 14. Maiden name Elizabeth Leubacker

15. Birthplace Germany

16 (a) Informant Loretta Seipple

(b) Address 3124 E Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18 1949 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Donnell

18 (a) Funeral director John G Mulvaney

(b) Address 3000 E Balto Md

19 (c) JAN 16 1949 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 15 1949 at 10.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 5 1947 to JAN. 15 1949, and that I last saw h. I.M. alive on JAN. 10 1949.

Immediate cause of death	Duration
Secondary Malignant Melanema, generalized	18 mos
Due to	
Due to	
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Melvin N. Boreham M. D.

Address 2030 W. Fayette St Date signed 1/15/49

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BIRTH NO. G70559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70559

1. NAME OF DECEASED (Type or Print): Barr, Edna

2. DATE OF DEATH: 1/13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland [redacted] 1519 Division Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 939 Brevard Street 11-2

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: 6 years (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Married	8/11/15	33	4 / 3	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mullins, S.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis
DUE TO
(B) Tuberculosis of Peritoneum
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Anemia, Hypoproteinemia

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: July 1948
19B. MAJOR FINDINGS OF OPERATION: Tbc Peritonitis
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/19/48, 19__, *to* 1/13, 1949 *that I last saw the deceased alive on* 1/13, 1949, *and that death occurred at* 12 59 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dr Marcus N. Moore Sr M. D.
23B. ADDRESS: Provident Hospital
23C. DATE SIGNED: 1/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): 1/16/49
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Cedar Hill Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. L. Halstead
ADDRESS: 918 Druid Hill Ave, 13B

VS 150

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G70560

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70560

BIRTH NO.

1. NAME OF DECEASED (Type or Print): (VIRGIE) VIRGINIA DAVIS

2. DATE OF DEATH: 1/12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1514 Division St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident

C. Length of stay in Baltimore: 10yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 913 W. Mulberry 18-1

5. SEX: F
6. COLOR or RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 9/17/1907
9. AGE (In years last birthday): 41
If Under 1 Year: Months 3 Days 26
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Gloucester, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Stokes
14. MOTHER'S MAIDEN NAME: Sarahann Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Woodard-Norfolk, Va. ADDRESS 739 Johnson Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Dec. 27 48
DUE TO
(B) Atherosclerotic Plaque — 1-12-49
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-27 19 48 *to* Jan 12 19 49 *that I last saw the deceased alive on* Jan 12 19 49, *and that death occurred at* 5:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Provident Hospital
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): A.A.County, Md. 1-12-49
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Charles G. Cooper-512 N.Carrollton

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Russell, Mamie

2. DATE OF DEATH: 1-14-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md. 20-7
D. STREET ADDRESS (If rural, give location): 317 Lyndhurst St.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 12/11/1880
9. AGE (In years last birthday): 68
If Under 1 Year: Months: 2 Days: 5
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Isreal Brown.
14. MOTHER'S MAIDEN NAME: Sarah Burgoyne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage

DUE TO

(B) arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-6, 1949, *to* 1-14, 1949 *that I last saw the deceased alive on* 1-14, 1949, *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Dr. L. J. Finkell, M. D.
23B. ADDRESS: Franklin Square Hos.
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 17/49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1949
REGISTRAR'S SIGNATURE: Warrington Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Nutzle
ADDRESS: 4401 Edmondson Ave.

VS 150

G70562 420.1 G70562

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Seth N. Frey SR.

2. DATE OF DEATH: 1/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-1
D. STREET ADDRESS (If rural, give location): 1022 Pine Heights Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	widow	11/2/75	73	2	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Frey
14. MOTHER'S MAIDEN NAME: Charlotte Humphrey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. J. W. Frey ADDRESS: 1022 Pine Heights Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Posterior Coronary Occlusion 1 week
DUE TO Coronary Sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Arteriosclerotic
DUE TO Cardio-Vascular Disease

(C) Anterior Coronary Occlusion 6 months

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 12, 1949 *to* Jan. 14, 1949 *that I last saw the deceased alive on* Jan. 14, 1949 *and that death occurred at* 7 30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Stephen R. Paduano M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 1-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1.17.49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1949
REGISTRAR'S SIGNATURE: Livingston Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Wiltshire ADDRESS: 4101 Edmondson Ave

VS 150

937

G70563

BALTIMORE CITY HEALTH DEPARTMENT 491 G70563

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK EDWARD FISHER

2. DATE OF DEATH Jan. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

C. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 15 N. Duncan St. 1-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
M	C	married	Aug. 2, 1889	59	5	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Sparrows Pt. Md.	U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		Mrs. Daisy Austin	15 N. Duncan St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchopneumonia	
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an ~~Autopsy~~ Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

~~Autopsy~~, Inspection or Inquiry

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George L. Merrill M.D.		1/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 17, 1949	Mt. Calvary	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams M.D.	Holland Funeral Home	1631 Druid Hill Ave.

VS 151

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G70564 ✓ 422.1 G70564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) WILLIAM W. ROBINSON
2. DATE OF DEATH January 14, '49
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 509 Bloom Street
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
c. Length of stay in Baltimore 50 yrs (Yrs. Mos. Days)
D. STREET ADDRESS (If rural, give location) 509 Bloom Street 14-3
5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 8, 1884
9. AGE (In years last birthday) 64 (If under 1 Year: Months 2, Days 6; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business man
10B. KIND OF BUSINESS OR INDUSTRY Grocery
11. BIRTHPLACE (State or foreign country) Tarboro, N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Elijah Robinson
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Addie Robinson ADDRESS 509 Bloom St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Disease — Interval between onset and death: 1 yr. ?

DUE TO

(B) Cerebral Hemorrhage — 15 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 19X9, *to* Jan 1X, 19X9, *that I last saw the deceased alive on* Jan 11, 19X9, *and that death occurred at* 10.50 Am., *from the causes and on the date stated above.*

23A. SIGNATURE E. William Frey M. D.
23B. ADDRESS 1928 Penna Ave
23C. DATE SIGNED 1/15/X9

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Jan. 14, '48
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn
24D. LOCATION (City, town, or county) Baltimore, (State) Maryland,

DATE RECEIVED BY LOCAL REGISTRAR JAN 20 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Mrs. George H. Holland 1631 Druid Hill Ave.

VS 150

937

G70.565 331 304 G70.565

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): FLORENCE SPICER

2. DATE OF DEATH: JAN 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3515 KESWICK RD.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3515 KESWICK ROAD

C. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTO CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO, MD.
D. STREET ADDRESS (If rural, give location): 3515 KESWICK ROAD. 13-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
FEMALE	WHITE	WIDOW	NOV 23 1863	85				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWORK		MARYLAND	U. S.

13. FATHER'S NAME: LUKE PEARCE

14. MOTHER'S MAIDEN NAME: JANE SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
-	-	-

17. INFORMANT: HORACE N. SPICER - ADDRESS: 3515 KESWICK RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Hemorrhage	72 hrs
ANTECEDENT CAUSES	DUE TO (B) Arteriosclerosis & Chronic Interstitial Nephritis	2 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Senility. Etc	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1st 1946 *to* Jan 16th, 1949, *that I last saw the deceased alive on* Jan 13th 1949 *and that death occurred at* 11:40 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. A. Lieich, M. D.	3615 Forest Ed Balto Md	Jan 14th 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 17/49	Laurel Ridge	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 16 1949	Washington Williams, M.D.	Fenatius E. Donovan	3638 Roland Ave.

VS 150

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G70566 BALTIMORE CITY HEALTH DEPARTMENT 475 G70566

BIRTH NO. B.C. 48-2339 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) BARBARA TURNER

2. DATE OF DEATH January 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
210 West 25th Street 12-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white		Oct. 19, 1948		2	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore	

13. FATHER'S NAME
Howard Turner

14. MOTHER'S MAIDEN NAME
Barbara Heavel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Howard Turner	210 W. 25th, St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Upper respiratory infection

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George L. Merrill M.D.		January 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 17-49	St. Mary's (Hampden)	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 16 1949	Courtesy for Williams, M.D.	Frank H. Lentz	814 N. 36th St.

VS 151

104a

Correct age is especially important. Physician, please write plainly.

G70567 — 420.1 — G70567

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MARY MURPHY

2. DATE OF DEATH: 14 JAN 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BALTO
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 603 E. Biddle — 4 01

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: 30 Oct 1872
9. AGE (In years last birthday): 76
If under 1 Year: Months, Days
If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTO
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Murphy
14. MOTHER'S MAIDEN NAME: Elizabeth Donnelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Nephew — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Disease — 10 years

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 JAN 1949 *to* 14 JAN 1949, *that I last saw the deceased alive on* 14 JAN 1949, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: John A Ferris M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 14 JAN 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 18, 1949
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Rita Wiedefeld — ADDRESS: 900 E. Biddle St.

VS 150

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G70568 ✓ H22.1 G70568

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Patrick F. Reddington.

2. DATE OF DEATH: 1-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. 9 Mos. 03 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 1108E Thirty-Sixth Street

5. SEX: M
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single.
8. DATE OF BIRTH: 11-1-1874
9. AGE (In years last birthday): 74 — If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10B. KIND OF BUSINESS OR INDUSTRY: Contracting

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Patrick Reddington.
14. MOTHER'S MAIDEN NAME: Elizabeth Devine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: John P. Reddington. ADDRESS: 1108 36th Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Renal Failure
DUE TO
(B) Cardiac Failure - Congestive
DUE TO
(C) Arteriosclerotic C-V Disease

ANTECEDENT CAUSES

II — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Fracture - left Hip; Hx of Gastric Ulcer

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION: Ulcerative - Hemorrhage
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Hospital
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Jenkins Memorial Hospital
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: December 28, 1948 (?) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Slipped and fell to the floor

22. I hereby certify that I attended the deceased from Jan. 14, 1949, to Jan. 15, 1949, that I last saw the deceased alive on Jan 14, 1949, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE: Ethel E. Rodwigo M. D.
23B. ADDRESS: St Agnes Hospital.
23C. DATE SIGNED: 1/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-17-49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Rita Wiedefeld
ADDRESS: 900 E. Biddle St.

E.A. Rodwigo3

186a

B.C. 49-000 67

G70569

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

451 G70569

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby Girl Hyson

2. DATE OF DEATH: 1/14/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MARYLAND B. COUNTY: Balto. City.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. Gen'l.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 23-03

c. Length of stay in Baltimore: Yrs. 11 Mos. Days

D. STREET ADDRESS (If rural, give location): 1213 Light St. (Rear)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
FEMALE	W	SINGLE	1-3-49			11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Maryland	U.S.A.

13. FATHER'S NAME: Richard W.

14. MOTHER'S MAIDEN NAME: Clara E. (Jackson)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mary [illegible]	[illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningitis Purulent — Interval between onset and death: 1 day

DUE TO

(B) Meningmyelocoele — Interval between onset and death: 11 days

DUE TO

(C) Spina Bifida

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 3, 1949 *to* Jan 14, 1949 *that I last saw the deceased alive on* Jan 14, 1949 *and that death occurred at* 2:37 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marion C. Hyson Jr. M. D.	So. Balto Gen. Hospital	Jan. 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	1-17-49	Glen Haven	Glen Burnie

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 16 1949	Huntington Williams, M.D.	James J. McCarey	1308 Fort Ave.

VS 150

157B

G70570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181 Registered No.

G70570

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs Sally E. Summers

2. DATE OF DEATH: 1/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MARYLAND B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): City. 27-18

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

D. STREET ADDRESS (If rural, give location): 5112 CORDELIA AVE.

c. Length of stay in Baltimore: 2 Yrs. Mos. Days

5. SEX: FEM. | 6. COLOR OR RACE: White | 7. (WIDOWED) DIVORCED (Specify)

8. DATE OF BIRTH: Sept 3, 1872

9. AGE (In years last birthday): 76 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Hood.

14. MOTHER'S MAIDEN NAME: Suzanne Gosnell.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO | (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Neoplasm of Urinary bladder

DUE TO Unclassified - & Metastases

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: NONE. | 19B. MAJOR FINDINGS OF OPERATION: NONE.

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NONE | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): NONE. | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): NO.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): NO. m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/3, 1949, *to* 1/15, 1949, *that I last saw the deceased alive on* 1/15, 1949, *and that death occurred at* 4A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard M Garrott M. D. | 23B. ADDRESS: Church Home & Hosp | 23C. DATE SIGNED: 15 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify): B. | 24B. DATE: 1-18-49 | 24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet | 24D. LOCATION (City, town, or county) (State): Mt Olivet

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: James L. McCreery | ADDRESS: 130 S Fort Ave.

VS 150

52B

✓ 600.0

G70571 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70571 — Registered No.

1. NAME OF DECEASED (Type or Print): ALVERDA S. SLAGLE

2. DATE OF DEATH: 1-13-49 ~~1/17/49~~

3. PLACE OF DEATH:
a. Baltimore City, Maryland - 3045 Mayfield Ave
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 3045 Mayfield Avenue — 26-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	M	3/3/1901	47	10	10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Pennsylvania	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harvey Hase	Emma Sorver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Family - Same	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uraemia

DUE TO

(B) Bilateral Pyelonephritis.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1948, *to* 1-13, 1949 *that I last saw the deceased alive on* 1-17-49, 19___, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Denis J. McGrath M. D.	1E. Randall St	1-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	I/17/49	Cedar Hill	Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 16 1949	(Deputy) for Matthews, M.D.	James L. McCarty.	- 130 E. Fort Ave.

VS 150

133a

B.C. 49-03042 ✓ 1960.0 G70572

BIRTH NO. G70572

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

1. NAME OF DECEASED (Type or Print) Charles Pollard Jones

2. DATE OF DEATH January 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hosp.

c. Length of stay in Baltimore 3 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3512 Hayward Ave. 27-16

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W.	— infant.	1-12-49			3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Md.	

13. FATHER'S NAME Rev. Leander Jones

14. MOTHER'S MAIDEN NAME Roslin Francis Freeman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	(mother)	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage, intracranial (not verified at autopsy)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 days.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-12, 1949 *to* 1-15, 1949 *that I last saw the deceased alive on* 1-14, 1949 *and that death occurred at* 4 40a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Cohen M. D.	West Baltimore Gen'l Hosp	1-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
		Meadowridge	Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 16 1949	Huntington for Miss [illegible]	Lasing Byers.	5005 Park Heights Ave Balto 15, Md.

VS 150

160a

Osf 4670573 ✓ X 443 670573

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Edna Hossey

2. DATE OF DEATH: JAN 15 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Somerset
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Crisfield
D. STREET ADDRESS (If rural, give location): 133 South 4th St

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Single	11-11-01	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sea Food Worker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles Morgan
14. MOTHER'S MAIDEN NAME: Nettie Waters
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	6 wks
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Hypertensive cardiovascular disease	8 yrs.
DUE TO		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)	Diabetes mellitus	about 6-8 yrs.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES [X] NO [ ]
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-13-, 1948, *to* 1-15, 1949, *that I last saw the deceased alive on* 1-15, 1949, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Bertram E. Sprotlin, M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 19, 1949
24C. NAME OF CEMETERY OR CREMATORY: Lawsonia Cemetery
24D. LOCATION (City, town, or county) (State): Crisfield, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Bradshaw Funeral Parlors
ADDRESS: Crisfield, Maryland

VS 150

61

G70574 Certificate Corrected 1-19-49 522 ✓ 334 G70574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BESSIE (E.) COSTELLO

2. DATE OF DEATH: January 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 811 Brice Street 16 0 4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	Oct 1st 1887	61	3	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waitress	Balto City School Board	Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Reathman	Mollie Plummer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Michael Costello	811 N. Brice St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH

XXXX Cerebral edema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
M.D.		1-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/18/49	Western	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	William Cook Inc.	1217 St. Paul St.

VS 151

111c

G70575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70575

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George N. Baker

2. DATE OF DEATH: 15 Jan. 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 324 E. 20th St 1-04

5. SEX	6. COLOR OR RACE	7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED (Specify)~~	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	10/10/1870	78	3	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Co. Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Charles Baker

14. MOTHER'S MAIDEN NAME: Eliza Amos

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Buena Zeckman ADDRESS: 1327 Grafton Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture Cervical Vertebrae, Left Shoulder Girdle, Left Radius and Ulna, Left Ribs (4th-7th), Pelvis. — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardio-Vascular Disease with Cerebral Sclerosis — 2 yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Mental Depression — 2 yrs.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Balto. City Hospital

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Balto. City Hospital "B" Bldg.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 15, 1949 2:40P m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21F. HOW DID INJURY OCCUR?: Jumped from 4th floor window

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: 16 Jan. 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/18/49

24C. NAME OF CEMETERY ~~OR CREMATORY~~: Cedar Hill

24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm Cook, Inc. ADDRESS: 127 St. Paul St.

VS 151

164E

0576 ✓ 155 G70576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): August E. Langstrom

2. DATE OF DEATH: 1/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1602 Hollins St. 19-04

5. SEX	6. COLOR OR RACE	7. ~~SINGLE, MARRIED~~ WIDOWED, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	10-13-1892	56	3	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ship Yard Worker

10B. KIND OF BUSINESS OR INDUSTRY: Md. Dry Dock

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: August E. Langstrom

14. MOTHER'S MAIDEN NAME: Mary Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Portia I. Langstrom ADDRESS: 1602 Hollins St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
(B) Primary Carcinoma of Liver
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 Jan., 1949, *to* 15 Jan., 1949, *that I last saw the deceased alive on* 15 Jan., 1949, *and that death occurred at* 5:01 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John Robert Shell M. D.

23B. ADDRESS: Mercy Hospital

23C. DATE SIGNED: 1/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-18-49

24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn

24D. LOCATION (City, town, or county) (State): Eastern Ave. Extended

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 150

46F

0577 ✓ 154 G70577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Florence Johnston
2. DATE OF DEATH: 1-15-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-0 r
D. STREET ADDRESS (If rural, give location): 625 S. Potomac St. #24

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W		Nov 24th 1873	75	1 / 21	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	—	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Ellison	Mary Wood.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No —		Albert Ellison	same add

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A)	Cardio Respiratory Failure	Immediate
DUE TO (B)	Carcinoma of Rectum	
DUE TO	And generalized metastasis to peritoneum and organs in pelvic cavity	
(C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-11-49	Carcinoma of Rectum - metastasis peritoneum	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-4, 1949, to 1-15, 1949, *that I last saw the deceased alive on* 1-15, 1949, *and that death occurred at* 12 45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
M K Brendler	The Maryland General Hospital	1-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-18-49	Oak Lawn	Eastern Ave. Extended

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

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0578 ✓ 350- G70578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): BRUNO MARTIN KOEHLER

2. DATE OF DEATH: Jan. 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 954 Franklintown Road

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 954 Franklintown Road 16-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	9/16/1890	58	3 / 28	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Watchmaker	Own Business	Germany	U.S.A.

13. FATHER'S NAME: Bruno Koehler

14. MOTHER'S MAIDEN NAME: Agnes Mueller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	Mrs Marta A. Koehler, 954 Franklintown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Encephalitis — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs.

DUE TO Parkinsonian Syndrome

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Arteriosclerosis with arteriosclerotic

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. type heart disease with cardiac hypertrophy & hypostasis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None.		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1, 1949 *to* Jan 14, 1949, *that I last saw the deceased alive on* Jan 12, 1949, *and that death occurred at* 12 noon, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm Michel M. D.	2901 Edmondson Ave	January 15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 17th 1949	Western	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 17 1949	Huntington Williams, M.D.	Wm Cook Inc. 1217 St. Paul St.

VS 150

937

0579 BALTIMORE CITY HEALTH DEPARTMENT 420.1 G70579

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) FANNIE ELLISON SALIGMAN

2. DATE OF DEATH 1/15/49 At 8.30 PM

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6910 Fielfcrest Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 58 yrs Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 6910 Fieldcrest Road 27-20

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Divorced	1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	—	Russia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Boris Ellison	Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Mrs Samuel Feldman	6910 Fielderest Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Vascular Disease	
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
John R Davis,			1/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 17, 1949	Hebrew Washington Road	Washington Blvd Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	Sol Levinson & Bros	1126 W North av

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670.580 ✓ 230 (?) 670.580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert C. Sheckeles

2. DATE OF DEATH: 1/14/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1824 Bolt Street 24-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	White	Married	January 10, 1902	46				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Boiler Maker		Maryland	U.S.A.

13. FATHER'S NAME: Fletcher Sheckeles

14. MOTHER'S MAIDEN NAME: Waters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Enteritis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO Cause undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute Splenic Tumor — 4 days

DUE TO Cause undetermined

(C) Pulmonary Edema — 12 hrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cirrhosis Hepatic — ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 12, 1949 *to* Jan 14, 1949, *that I last saw the deceased alive on* Jan 14, 1949, *and that death occurred at* 5:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John M. Blanton Jr M. D.	South Baltimore General Hospital	Jan 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	1/15/49	Glen Haven	Annapolis Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	John F. Denny Inc	715 Eight St.

VS 150

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G70581 ✓ 174 G70581

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): SARAH E. BOWEN

2. DATE OF DEATH: 1/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 117 CHURCHILL ST.
c. Length of stay in Baltimore: — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 117 CHURCHILL ST. 22-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	MARRIED	4/29/1899	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE	—	CALVERT Co. MD.	

13. FATHER'S NAME: JAMES FOWLER

14. MOTHER'S MAIDEN NAME: EMMA BUCHLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—		MR. JAMES BOWEN	6325 BROADWAY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) -Carcinoma - Uterine organs — INTERVAL BETWEEN ONSET AND DEATH: 6 Mos.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 10, 1949 to Jan 14, 1949 *that I last saw the deceased alive on* Jan 13, 1949 *and that death occurred at* 11:45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1279 Fulham St	1/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	1/17/49	CEDAR HILL	RITCHIE HIGHWAY

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	JOHN F. DENNY INC.	715 LIGHT ST -30

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570582 BALTIMORE CITY HEALTH DEPARTMENT 150 G70582

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Garland Clifton Rich
2. DATE OF DEATH: Jan. 15, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Home
c. Length of stay in Baltimore: Yrs. Life Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. City
D. STREET ADDRESS (If rural, give location): 1931 Edmondson Ave. 20 01
5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 3-13-1902
9. AGE (In years last birthday): 46 — If Under 1 Year: Months 10 Days 2 — If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Harry Rich
14. MOTHER'S MAIDEN NAME: Laura Coates
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS: Beatrice Martin 1931 Edmondson Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardeta — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

(B) Carcinoma Esophagus — unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION: Carcinoma Esophagus
20 AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I Attended the deceased from* 1/12/49 19__ *to* 1/13/49 19__, *that I last saw the deceased alive on* 1/13/49 19__, *and that death occurred at* 9:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Helen L Jordan M. D.
23B. ADDRESS: 1931 Edmondson Ave
23C. DATE SIGNED: 1/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: 1-17-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Balto. City

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Samuel W. Sullivan, Jr.
ADDRESS: 1011 Arlington

VS 150

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570583

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

592 43

Registered No. 570583

1. NAME OF DECEASED (Type or Print) Anna Mohr

2. DATE OF DEATH Jan 15 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1501 E Lafayette Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1501 E Lafayette
C. CITY OR TOWN Baltimore 2 06
(If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow
8. DATE OF BIRTH Dec 3 1872
9. AGE (In years last birthday) 76 — If Under 1 Year: Months 1, Days 12 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto
12. CITIZEN OF WHAT COUNTRY? U S
13. FATHER'S NAME Michael Salzman
14. MOTHER'S MAIDEN NAME Amelia Russell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Hilda Harris ADDRESS 1501 E Lafayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Hypertensive Vascular Disease — 5 yrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Chronic Nephritis — 5 yrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
20 AUTOPSY? YES ☐ NO ☐
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1 1948 *to* Jan 16 1949, *that I last saw the deceased alive on* Jan 15 1949, *and that death occurred at* 10-30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Ed Jul Hall M D — M. D.
23B. ADDRESS 1631 E North Ave
23C. DATE SIGNED Jan 17 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Jan 19 49
24C. NAME OF CEMETERY OR CREMATORY Balto Cem
24D. LOCATION (City, town, or county) (State) Balto

DATE RECEIVED BY LOCAL REGISTRAR JAN 18 1949

REGISTRAR'S SIGNATURE Huntington Williams M D

25. FUNERAL DIRECTOR Welsh Funeral Home ADDRESS 2008 Orleans

1310

G70584 NORVELL ✓ X 560.4 G70584

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): William J. Norvell

2. DATE OF DEATH: Jan 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Md General Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md. Gen. Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Port Deposit B. COUNTY: Cecil Co - Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	W White	Widower	May 4, 1893	55 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? Cecil
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: ? unknow
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Robert Norvell ADDRESS 1908 Pleasant View ave Boothwyn Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Circulatory & Respiratory failure following

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Repair of Diaphragmatic Hernia, left.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Jan 16, 1949
19B. MAJOR FINDINGS OF OPERATION: Hiatus Hernia, left; Peptic Ulcer
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Frank A. Faraino M. D.
23B. ADDRESS: Md. Gen. Hosp.
23C. DATE SIGNED: 1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 20/49
24C. NAME OF CEMETERY OR CREMATORY: LAWNCROFT Lessner of to Crm
24D. LOCATION (City, town, or county) (State): Chester Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. C. Tyson ADDRESS: Rising Sun Md.

VS 150

1220

670585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

434.1 670585

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Samuel W. Stevenson.

2. DATE OF DEATH Jan. 12, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland Baltimore, Md.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1370 Calhoun Street

c. Length of stay in Baltimore ~~Life~~ 55 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1370 Calhoun Street 15-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Negro	Married	4/8/79	69	9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) St. Marys' County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Robert Stevenson ADDRESS 1014 Stoddard Ct.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Bronchi-pneumonia — 2 days

DUE TO

(B) Congestive Cardiac failure — 3 mos.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/5 19[illegible] *to* 1/12 19[illegible] *that I last saw the deceased alive on* 1/12 19[illegible] *and that death occurred at* 1:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M. D.

23B. ADDRESS [illegible]

23C. DATE SIGNED 1/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Jan. 17, 1949

24C. NAME OF CEMETERY OR CREMATORY Mt. Zion

24D. LOCATION (City, town, or county) Landsdowne 27, Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR JAN 17 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Charles R. Law ADDRESS 802 Mad. Ave.

VS 150

107

G70586
BIRTH NO.

✓ 420.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70586

1. NAME OF DECEASED (Type or Print): LILLIAN WALDNER

2. DATE OF DEATH: January 14, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1754 Darley Avenue
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1754 Darley Avenue 8 05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	Feb. 12, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.

13. FATHER'S NAME: John Peifer

14. MOTHER'S MAIDEN NAME: Sophia Schauffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	none	August C. Waldner	1754 Darley Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	—
DUE TO (B)	Arteriosclerotic Cardiovascular Disease	3 years
DUE TO (C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 46, *to* Jan. ____, 19 49, *that I last saw the deceased alive on* Jan 3, 19 49, *and that death occurred at* 2:00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lee M. Zimmerman M. D.	2858 Harford Rd.	15 Jan. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/18/49	Baltimore Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC.	

VS 150

BALTIMORE, MARYLAND 93D

✓ 442 G70587

G70587

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Francis McKinley Fowler — Francis McKinley Fowler

2. DATE OF DEATH: Jan. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Md. General Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp
C. Length of stay in Baltimore: 50 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1808 N. Montford Avenue

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 21, 1896
9. AGE (In years last birthday): 52 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffer
10B. KIND OF BUSINESS OR INDUSTRY: Yellow Cab Co.
11. BIRTHPLACE (State or foreign country): Virgini a
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Francis P. Fowler
14. MOTHER'S MAIDEN NAME: Margaret McGuffen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-01-2941
17. INFORMANT: Mrs. Lona M. Fowler — ADDRESS: 1808 N Montford Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 7 days.
DUE TO
(B) hypertensive cardio vascular renal disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 7, 1949 *to* Jan 17, 1949 *that I last saw the deceased alive on* Jan 14, 1949, *and that death occurred at* 8:45 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Betty May Young M.D. M. D.
23B. ADDRESS: Maryland General Hospital
23C. DATE SIGNED: Jan 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/18/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: NORTH AVE. & BROADWAY

VS 150

131a

G70588
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

236 G70588
Registered No.

1. NAME OF DECEASED (Type or Print): Miss Pauline Nonnsen
2. DATE OF DEATH: Jan 15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hosp. Tal
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2902 Overland Ave 2102

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	Months	Days	If Under 24 Hours: Hours	Min.
F M	White	Single	July 19, 1893	55	3	27		

10A. USUAL OCCUPATION (Give kind of work, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk		Maryland	U.S.A.

13. FATHER'S NAME: Mr. William Nonnsen.
14. MOTHER'S MAIDEN NAME: Miss Bertha Munster.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	—		Hospital Record	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Perforation of Urinary Bladder due to Infiltration of Papilloma of Bladder — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-5-49	Papilloma of bladder	YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/3 49 *to* 1/15, 19 49 *that I last saw the deceased alive on* 1/15, 19 49 *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Kirk Moore MD M. D.	Church Home & Hospital	1-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 19. 49	Parkwood Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	HENRY SANDER & SONS. INC.	

VS 150

Baltimore Md. 56E

G70589 ✓ 422.2 G70589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 Wilmot Ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 10-02
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Wilmot Ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Tomlinson (CHARLES TOMLINSON)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband~~ or wife: Leah Tomlison
6 (c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Nov. 28, 1867

8. AGE: Years 81 | Months 1 | Days 18 | If less than one day: hr. min.

9. Birthplace: Doylestown Pa
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: John Tomlinson
13. Birthplace: Pa

MOTHER
14. Maiden Name: Melinda Ginsley
15. Birthplace: Pa

16 (a) Informant: Lea T Tomlison
(b) Address: 1004 Wilmot Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19, 1949 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Baltimore Md

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: Baltimore Md.

19 JAN 17 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 16 1949 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16 1949 to 1/16 1949 and that I last saw h~~im~~ alive on 1/15 1949.

Immediate cause of death: Cardiac failure — Duration: 7 d

Due to: Myocarditis, chronic

Due to:

Other Conditions: Pulmonary edema

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSI... Underlin... cause to w... death should ... charged sta... tically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: H. M. MacMurchy M. D.
Address 901 Bmca Date signed 1/16/49

VS 150

93D

Physicians: please write the causes of death clearly and legibly. Cause of death which ... correct age is especially important.

70590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70590

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH VINCENT AGNELLO

2. DATE OF DEATH: January 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2629 Aisquith Street 9-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	Mar. 10. 1914	34		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	Garage	Maryland	U.S.A.

13. FATHER'S NAME: Anthony Agnello

14. MOTHER'S MAIDEN NAME: Rose Culatta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	none	Mrs. Helena Agnello- 2629 Aisquith St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet-wound of spinal cord.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ ~~CAUSE OF~~ DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	2629 Asquith Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
January 8, 1949 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Firearms

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George G. Merrill M.D.	☐ / ☒ / ☐	1-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 18. 1949	Parkwood Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 17 1949	Huntington Williams, M.D.	HENRY SANDER & SONS. INC.

VS 151

Baltimore Md. 184

G70591 ✓ 157 G70591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DR. Howard J. Maldeis

2. DATE OF DEATH: 1-15-48 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland University Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp - Balto - Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 4421 Marble Hall Road 27-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	MARRIED	Sept 20. 1879	69	3	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PHYSICIAN	Medical Examiner	Balto.	U. S. A.

13. FATHER'S NAME: Frederick W. Maldeis

14. MOTHER'S MAIDEN NAME: Martha E. Loeber.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	—	—	Howard J. Maldeis Jr.	4404 Marble Hall Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Body — INTERVAL BETWEEN ONSET AND DEATH: 67 days

DUE TO

(B) of the Pancreas with metastasis to Liver

DUE TO

(C) arteriosclerotic CVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12/23	large mass probably arising from body of Pancreas	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JAN 1 19 49 *to* JAN 15 19 49 *that I last saw the deceased alive on* Jan 15 19 49 *and that death occurred at* 6·45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
G. O. Peterson M. D.	University Hosp	1-15

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-17-49	Druid Ridge	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams M.D.	John D. Mitchell Sons	1900 Eutaw Place

VS 150

462

G70592 ✓ 331

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70592

1. NAME OF DECEASED (Type or Print): Flora E. Langdon

2. DATE OF DEATH: Jan. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Allston Apts., Chas. & 32nd
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Allston Apts., Charles & 32nd Sts.

c. Length of stay in Baltimore: 28 Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	October 26, 1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	own home	Canada	U. S.

13. FATHER'S NAME: George Parker

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	none	Paul H. Longdon	Allston Apartments

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage. — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) Jan 6-1949 — (B) 20 yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 6 1949 *to* Jan 15, 1949, *that I last saw the deceased alive on* Jan 15, 1949, *and that death occurred at* 12 30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Anthony J. Diner M. D.	800 W 33rd St.	1-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1-18-49	Druid Ridge	Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	John O. Mitchell & Sons, Inc.	1900 Eutaw Pl.

VS 150

John O Mitchell Sons, 83a

G70593 ✓ 416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70593

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Robert E Stanley
2. DATE OF DEATH: JAN-14-1949
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto - Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1913 Aisquith st
c. Length of stay in Baltimore: 30 yrs (Yrs. Mon. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1913 Aisquith st 9-08
5. SEX: M
6. COLOR OR RACE: C
7. SINGLE! MARRIED, WIDOWED DIVORCED (Specify): D
8. DATE OF BIRTH: Dec-14-1891
9. AGE (In years last birthday): 57 54 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Aireys Dorchester-Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Levi R. Stanley
14. MOTHER'S MAIDEN NAME: Carolina Thomas
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Ida Norris ADDRESS: 1634-Miller st

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH: Jan 12-1949

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypostatic Pneumonia, Cardiac Failure, Bed (Confinement)

DUE TO

(C) Hypertension (Rheumatic) Cardio Vascular Disease 2 yrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arthritis, Systemic Hypertension Arteriosclerosis 2 yrs

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1948 *to* Jan 14, 1949, *that I last saw the deceased alive on* Jan 14, 1949, *and that death occurred at* 41 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Ralph J. Yerrow, M. D.
23B. ADDRESS: 1429 E Monument St
23C. DATE SIGNED: Jan 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-18-49
24C. NAME OF CEMETERY OR CREMATORY: Aireys
24D. LOCATION (City, town, or county) (State): Aireys Dorchester - Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Holland Funeral Home 163-Hilmid Ave

VS 150

93c

G70594 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.0 G70594 Registered No.

1. NAME OF DECEASED (Type or Print): PAUL BATES
2. DATE OF DEATH: January 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 1331 Upton Street 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	Colored		1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Unknown	U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Maggie Thomas	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George L. Merrill M.D.	☑	1/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/20/49	Oliver Branch	Dudurdale Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	Wm a Jackson	916 Penna Ave 939

VS 151

G70595 ✓ 331 G70595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Andrew Elliott
2. DATE OF DEATH: 1-16-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 622 W. Redwood St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 13 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 622 W Redwood St. 4-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	C	Widowed	1-16-1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Charlotte Va	

13. FATHER'S NAME: Hope Elliotte
14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Lilia Elliott Williams	622 Redwood St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemmorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO Hypertension
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 5, 1949, to Jan 16, 1949, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Stewart M. D.	632 W. Franklin St	1-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-18-49	Mt. Calvary	Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams M.D.	Adolphus Halstead	975 Hollins

83a

(5 150)

670596 ✓ 420.1 670596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) FRANK. ARTHUR. COOK. 2. DATE OF DEATH Jan. 14 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 5323 Wesley. Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE maryland B. COUNTY Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md.
D. STREET ADDRESS (If rural, give location) 5323 Wesley. Ave 28 0 2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	married	Feb. 19 - 1885	63	10 / 5.	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Insurance Agent	Baltimore Md.	U. S. A.

13. FATHER'S NAME Eugene. Cook.
14. MOTHER'S MAIDEN NAME Mary. Markley.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
no	none.	William B. Cook - 5323 Wesley ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 days
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Arteriosclerosis
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 1/1, 1949, to 1/14, 1949, that I last saw the deceased alive on 1/14, 1949, and that death occurred at 6:10 P m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. Cleve Laughlin M. D.	400 N. Paca St.	1/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 18. 1949	Druid Ridge Cem.	Pikesville - Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 17 1949	Huntington Williams, M.D.	Jeannie Cook. 1600 W. Lyfer North Ave

VS 150

9+a

G70597 ✓443 G70597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Cecilia Veronica Grabiak

2. DATE OF DEATH: January 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's

c. Length of stay in Baltimore: 15 yr. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1716 N. Calvert

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	Single	November 8, 1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rooming House Owner	Private	Philadelphia	U.S.

13. FATHER'S NAME: John Grabiak

14. MOTHER'S MAIDEN NAME: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	--	--	Wm. Patrick Ray	1716 N. Calvert Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cerebral Hemorrhage — 22 days

DUE TO

(C) Hypertensive Cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arterial emboli to both lower extremities

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* December 24, 1948 *to* January 15, 1949, *that I last saw the deceased alive on* Jan. 15, 1949, *and that death occurred at* 12:55 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip A. Reed M.D.	1400 N. Caroline St., Balto.	Jan. 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 18, 1949	New Cathedral	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

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70598 Dr. Peake

BALTIMORE CITY HEALTH DEPARTMENT 162 G70598

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): John Schumm

2. DATE OF DEATH: Jan. 13. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2804 Arlington Avenue 27-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
male	white	married

8. DATE OF BIRTH: Feb. 23, 1882
9. AGE (In years last birthday): 66 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10B. KIND OF BUSINESS OR INDUSTRY: S.K. Plant

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Katherine Schumm ADDRESS: 2804 Arlington Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6-9 Months

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1-4-49
19B. MAJOR FINDINGS OF OPERATION: Metastatic Carcinoma Neck Glands
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1945 to 1-13 1949, that I last saw the deceased alive on 1-13 1949, and that death occurred at 11 P m., from the causes and on the date stated above.

23A. SIGNATURE: C. W. Peake M. D.
23B. ADDRESS: 4508 Harford Road
23C. DATE SIGNED: 1-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-17049
24C. NAME OF CEMETERY OR CREMATORY: Moreland Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road

VS 150

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G70599 ✓260 G70599

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): LILLIAN O. AINSWORTH

2. DATE OF DEATH: Jan. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2522 Robb St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2522 Robb St. 9-07

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced
8. DATE OF BIRTH: May 30, 1892
9. AGE (In years last birthday): 56 yrs. (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Thomas Owens
14. MOTHER'S MAIDEN NAME: Mollie Moyer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 215-18-5502
17. INFORMANT: Mr. Charles Ainsworth ADDRESS: 2522 Robb St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1940 —
DUE TO Chron - Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Diabetes Mellitus — 1940 —
DUE TO

(C) Acute Cardiac Dilatation — 1949

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1, 1945 *to* Jan 14, 1949, *that I last saw the deceased alive on* Jan 14, 1949, *and that death occurred at* 11:45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: B. W. Bishop M. D.
23B. ADDRESS: 503 Shrader
23C. DATE SIGNED: 1-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949
REGISTRAR'S SIGNATURE: Lexington Williams, M.D.
25. FUNERAL DIRECTOR: WILLIAM J. TICKNER & SONS ADDRESS: Balto., Md.

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G70600 ✓ X 420:1 443 G70600

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70600

1. NAME OF DECEASED (Type or Print): ELSIE CARLYLE SMITH
2. DATE OF DEATH: 1/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MD
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sparrows Point
D. STREET ADDRESS (If rural, give location): 531 E Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
F	W	divorced	FEB 7, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		PENNSYLVANIA	

13. FATHER'S NAME: JOHN SMITH
14. MOTHER'S MAIDEN NAME: JANE CHRISTIE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) THROMBOSIS - POST INF CEREB - DUE TO ELLAR ARTERY - LEFT

(B) ARTERIOSCLERODIC HEART DISEASE DUE TO CORONARY THROMBOSIS HYPERTENSIVE CVD

~~(C) CEREBRAL ARTERIOSCLEROSIS~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/13, 1949, *to* 1/14, 1949 *that I last saw the deceased alive on* 1/14, 1949, *and that death occurred at* 1:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald W. Mintzer M. D.	Church Home & Hosp.	1/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	1/18/49	Parkwood Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MR. JOHN McPHAIL, JR.

2. DATE OF DEATH: 1-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: 69 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): TOWSON
D. STREET ADDRESS (If rural, give location): 529 Allegheny Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	5-31-1876	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Director	James Robertson Mfg. Co.	Montreal, Canada	U.S.A.

13. FATHER'S NAME: JOHN McPHAIL

14. MOTHER'S MAIDEN NAME: ANNIE McCUBBIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no			MRS. CLEMENTINE McPHAIL	529 Allegheny Ave., Towson, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH

(B) Bronchogenic Carcinoma, right lower lobe — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Cardiovascular Disease

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-18, 1948 *to* 1-15, 1949 *that I last saw the deceased alive on* 1-14, 1949 *and that death occurred at* 2:17 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Frank Supplee, Jr. M. D	Union Memorial Hosp	Jan 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1.17.49	Druid Ridge Cem.	Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KATHERINE SOMERVILLE

2. DATE OF DEATH: Jan. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Methodist Home for the Aged 2211 W. Rogers Ave.
c. Length of stay in Baltimore: 51 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 W. Rogers Ave. 27-15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	Feb. 8, 1864	84 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ellicott City, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Somerville
14. MOTHER'S MAIDEN NAME: Mary Kuhn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Miss Mamie B. Fisher ADDRESS: 2211 W. Rogers Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	1-8-49
DUE TO (B)	Arteriosclerosis	10 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1949, *to* Jan 13, 1949, *that I last saw the deceased alive on* Jan 13, 1949, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Arthur J Davis M. D.
23B. ADDRESS: 900 W 32nd St.
23C. DATE SIGNED: 1-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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G70603 ✓ 420.1 G70603

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): OLIVER D. SHEPARD

2. DATE OF DEATH: Jan. 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY [redacted]

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 2307 Sulgrave Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Nov. 29, 1890	58 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
President	D. C. Elphinstone Co.	Cleveland, Ohio	

13. FATHER'S NAME: George C. Shepard

14. MOTHER'S MAIDEN NAME: Lula Day

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mrs. Jennie K. Shepard	2307 Sulgrave Av

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary thrombosis	Immediate
	DUE TO (B)	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 13, 1942 *to* Jan 5, 1949, *that I last saw the deceased alive on* Jan 5, 1949, *and that death occurred at* 9 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Arthur J. Davies M. D.	900 W 33rd St	1-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/17/49	Loudon Park Cem.	Loudon Park Cem.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	William J. Tickner & Sons	Balto., Md.

VS 150

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G70604 BALTIMORE CITY HEALTH DEPARTMENT 420.0 Registered No. G70604

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave.
(c) Hospital or institution: Jenkins Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 13-03
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cloverdale Rd. & Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MISS MARY CLARKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 6, 1868

8. AGE: Years	Months	Days	If less than one day
80	8	9	hr. min.

9. Birthplace IRELAND.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Patrick Clarke
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Patterson
15 Birthplace Ireland

16 (a) Informant MR. JEROME K. MEYER
(b) Address TEMPLE GARDEN APTS.

17 (a) Burial (b) Date thereof 1/18/49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 17 1949 Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15/49 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death CARDIO - RESPIRATORY FAILURE — Duration

Due to ARTERIOSCLEROSIS

Due to CARDIO-VASCULAR DISEASE

Due to L LEFT HEMIPLEGIA

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Shaw M. D.

Address 1000 Caton Ave. Date signed 1/15/49

VS 150

901

G70605 BALTIMORE CITY HEALTH DEPARTMENT 332 G70605

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Greenspring Ave
(b) Street address ~~Hospital or Inst.~~
(c) Hospital or institution: Levindale ~~Hospital~~
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County 15-38
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Garrison Boulevard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL GOGEL

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Poland (State, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER 12. Name Mathew
13. Birthplace Poland
MOTHER 14. Maiden Name Rachel
15. Birthplace Poland

16 (a) Informant Louis Gogel
(b) Address 2901 Garrison Boulevard
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-49 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location
18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place
19 (a) JAN 17 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17 1949, at 2 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1946 to 1-17 1949 and that I last saw h[illegible] alive on 1-17 1949.
Immediate cause of death Cerebral Thrombosis

Duration
2

Due to
Due to
Other Conditions Bronchiectasis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 1-17-49

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

836

G70606

BALTIMORE CITY HEALTH DEPARTMENT 420.1

CERTIFICATE OF DEATH

Registered No. G70606

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 27-20
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Fordleigh Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Macklin.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Irving

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day: hr.	min.
52				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Stanley Macklin
(b) Address 2803 Fordleigh Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 01-17-49 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Friendship Cem

18 (a) Funeral director Jack Lewis Inc
(b) Address 2166 Eutaw Place

19 (a) JAN 17 1949 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1949 at 10 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1949 to 1/16 1949 and that I last saw h[illegible] alive on 1/16 1949

Immediate cause of death Shock — Duration

Due to Probable acute myocardial infarction

Due to

Other Conditions Hyperventricular tachycardia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M.D.
Address WBGH Date signed 1/16/49

VS 150

94a

70607 ✓ 71 G70607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: Redwood & Greene Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 15-05
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Marks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Monroe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 59 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Louis Wersaner

13. Birthplace Russia

MOTHER 14. Maiden Name Fanny Wersaner

15. Birthplace Russia

16 (a) Informant Monroe Marks

(b) Address 3120 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-49 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2400 Eastern Place

19 (a) JAN 17 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16 1949, at 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1949 to 1-16 1949, and that I last saw h alive on 2:15 AM 1949.

Immediate cause of death cardiac failure — Duration

Due to uremia

Due to Carcinoma of uterine cervix

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/19/48

Major findings of operation: Ca cervix, grade IV

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James M. Brasua M.D.

Address University Hosp Date signed 1/19/49 M. D.

48a

VS 150

BIRTH NO. 570608

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

332 670608 Registered No.

1. NAME OF DECEASED (Type or Print): ELIZABETH BARNEY.

2. DATE OF DEATH: Jan 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1609 E. 25th St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1609 E. 25th St.

C. Length of stay in Baltimore: 2 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1609 E. 25th St. 8-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	widow	Sept 25 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework.		Wilkes Barre, Pa.	U.S.

13. FATHER'S NAME: Patrick O'Boyle

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	

17. INFORMANT: Mrs. Florence Renaud ADDRESS: 1609 E. 25th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteriosclerosis	3 years
DUE TO (B)	old age	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	cerebral thrombosis	2 years
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb, 1947, *to* Jan 16, 1949, *that I last saw the deceased alive on* Jan 12, 1949, *and that death occurred at* 7a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert K. Mortimer Jr M.D. 23B. ADDRESS: 2706 St Paul St 23C. DATE SIGNED: 1/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	Jan 17/49	Wilkes Barre Pa	Pennsylvania.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Forster E. Sowers ADDRESS: 3638 Roland Ave

Vs 150

836

670609 ✓ 420.1 670609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): JOHN BERNARD CREHAN
2. DATE OF DEATH: January 16, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 819 N. Howard Street 11-03
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1-30-1896
9. AGE (In years last birthday): 51 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph B. Crehan
14. MOTHER'S MAIDEN NAME: Hannah M. Hopkinson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Eugene Crehan ADDRESS: 202 N. Monastery Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]
21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Carl L Hoyer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-19-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. L. Schwab ADDRESS: 2101 Frederick Ave.

VS 151

94a

G70610 ✓ 491 G70610

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Patricia Prato

2. DATE OF DEATH: January 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR [redacted]: St. Joseph's (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 3½ yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1409 S Guaryan 21-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, [redacted]D, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.		February 3, 1944	4 yr.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY:

13. FATHER'S NAME: Nicholas James Prato
14. MOTHER'S MAIDEN NAME: Dorothy Naomi

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Nicholas Prato ADDRESS: 1409 Guaryan St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchopneumonia.	
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 12, 1949 *to* Jan. 15, 1949, *that I last saw the deceased alive on* Jan. 15, 1949, *and that death occurred at* 3:35 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Phillip A. Peter, M.D. M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: Jan. 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/19/49
24C. NAME OF CEMETERY OR CREMATORY: Fostenburg
24D. LOCATION (City, town, or county) (State): Nebraska

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John B Connelly ADDRESS: 415 Eastern Ave

VS 150

10¢ Encl. 21, Md.

BIRTH NO. 670611

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

007 Registered No. 670611

1. NAME OF DECEASED (Type or Print): WILLIAM BUNDY

2. DATE OF DEATH: January 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1017 N. Carrollton ave 16 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Single	November 30, 1903	45	1	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sailor		Virginia	

13. FATHER'S NAME: William Bundy

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: Charles Jones, 1017 N. Carrollton ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis

(B) Tuberculous pneumonia.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.

23B CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☑
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 22, 1949	Mount Zion	Baltimore County

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Joseph A. Sisly 661 W. Baltimore St

VS 151

13B

BIRTH NO. G70612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581.0 G70612 Registered No.

1. NAME OF DECEASED (Type or Print): Ferdinand Adolph Spieker (Spiecker)
2. DATE OF DEATH: January 15, '49
3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mon. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1629 Balt St. 24-04
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Div.
8. DATE OF BIRTH: APRIL-11-1902
9. AGE (In years last birthday): 46 — If under 1 Year: Months 9, Days 4 — If under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist - B-O Road
10B. KIND OF BUSINESS OR INDUSTRY: Railroad.
11. BIRTHPLACE (State or foreign country): BALTIMORE MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: JOHN HENRY SPIEKER
14. MOTHER'S MAIDEN NAME: CHRISTINA F. EFFING
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-05-3412
17. INFORMANT: MARY A. FINDLING — ADDRESS: 1629 BELT ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) pneumonia
DUE TO
(B) cardiac failure
DUE TO
(C) Portal cirrhosis.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 12, 19[illegible], *to* Jan 15, 19[illegible], *that I last saw the deceased alive on* Jan 14, 1949, *and that death occurred at* 7½ a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Philip G. Pratt M.D. M. D.
23B. ADDRESS: 1400 N. Caroline
23C. DATE SIGNED: Jan 15 '49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-18-49
24C. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL
24D. LOCATION (City, town or county) (State): BALTIMORE MD.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949
REGISTRAR'S SIGNATURE: Cuthbert Williams, M.D.
25. FUNERAL DIRECTOR: Elizabeth Harle Inc. — ADDRESS: 115 E. WEST St.

124B

G70613

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

340-0 G70613

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Roger Cooper
2. DATE OF DEATH: 1/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland yes
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sydenham Hospital
C. Length of stay in Baltimore: 4 Yrs. 11 Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Edgewood
D. STREET ADDRESS (If rural, give location): —

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W		12/26/47	1	12	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Herbert E. Cooper Jr.
14. MOTHER'S MAIDEN NAME: Beatrice Dunn ✓
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No —
16. SOCIAL SECURITY NO: —
17. INFORMANT: Beatrice Cooper ADDRESS: Edgewood, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Damage
DUE TO
(B) Influenzal Meningitis — 4 months
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Natural Death	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 1/1 1949 *to* 1/16, 1949 *that I last saw the deceased alive on* 1/16, 1949 *and that death occurred at* 6 30 PM. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul Baxter M. D.	Sydenham Hospital	1/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jany 19/49	Bel Air Memorial	Bel Air, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	Joseph J. Slater	Bel Air Md

VS 150

32B

G70614 BALTIMORE CITY HEALTH DEPARTMENT H20.0 443 G70614

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Parkwyrth ave. (If rural give location) 9-01
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Gaskin (MARGARET D. GASKIN)

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John S. Gaskin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 26, 1867

8. AGE: Years 81 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Michael Burke
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Sheehan
15 Birthplace Ireland

16 (a) Informant Mrs. Nellie Merryman
(b) Address 615 Parkwyrth ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/49 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Washington, D.C.

18 (a) Funeral director Guy J. Evans Jr. Inc.
(b) Address 118 N. Mt. Royal Ave.

19 JAN 17 1949 (Date filed by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 1949 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13 1949 to 1/15 1949 and that I last saw h[illegible] alive on 1/15 1949.

Immediate cause of death: Hypertensive arteriosclerotic cardio-vascular dis. — Duration: ?

Due to

Due to

Other Conditions: Bronchopneumonia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 1. generalized arteriosclerosis 2. Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M. D.
Address WBGH Date signed 1/15/49

VS. 180

93D

Change Cause of death ✓ 007

G70615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70615

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Gladys Garrett (Blake)

2. DATE OF DEATH: 1/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 217 N. Fulton Ave. 19-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	married	Dec. 15, 1920	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
waitress		Baltimore County	

13. FATHER'S NAME: William Garrett

14. MOTHER'S MAIDEN NAME: Mollie Major

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Annie Travers	806 N. Caroline St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Undiagnosed Abortion — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Sepsis — over

DUE TO

(C) Pulmonary Tuberculosis Acute Fatty Degeneration of Liver

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Subacute metritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
[signature]			1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	1/18/49	Mt. Auburn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Cunningham Williams, M.D.	Robert L. Young	1216 E. Caroline St.

VS 151

013B

70616

BALTIMORE CITY HEALTH DEPARTMENT 331 G70616

CERTIFICATE OF DEATH

Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 Stricker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 16 or
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Stricker St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Lewellen Henry
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr) May 10 1903

8. AGE: Years 45 | Months | Days | If less than one day: hr. min.

9. Birthplace Alexander Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Va

MOTHER
14. Maiden Name Eliza Scott
15. Birthplace Va

16 (a) Informant Lewellen Henry
(b) Address 814 Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 | 19 | 49 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St

19 (a) JAN 17 1949 (Date rec'd by registrar) (b) Huntington Williams Registrar M.D.

VS 150

MEDICAL CERTIFICATION 1949

20. DATE OF DEATH 1-15 1949 at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1948 to 1-15 1949 and that I last saw h[illegible] alive on 1-14-49.

Immediate cause of death: Cerebral hemorrhage — Duration 2 days

Due to

Due to

Other Conditions: Hypertension — unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders
Address 1029 N. Stricker St Date signed 1-15-49 M.D.

83a

G70617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

550.1 G70617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): less than 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Montgomery
(c) City or town: Chevy Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 8403 Connecticut Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: DAVID NICOLAS HELMER

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 13, 1941

8. AGE: Years	Months	Days	If less than one day
7	5	3	hr. min.

9. Birthplace: NJ
(Town, county, and state)

10. Usual Occupation: Student

11. Industry or business:

FATHER
12. Name: Frank Helmer
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Hilda Caldwell
15. Birthplace: NJ

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 20. 49 (month) (day) (year)
(c) Cemetery or crematory: Bethesda
Location: Maryland

18 (a) Funeral director: W. R. Pumphrey
(b) Address: Bethesda - Md.

19 (a) JAN 17 1949 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 16 1949 at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1949 to Jan. 16 1949, and that I last saw him alive on Jan. 16 1949.

Immediate cause of death	Duration
Death following general anesthesia (N2O-Ether-Cyclopropane)	1 hr.
Due to: Acute appendicitis with rupture and localized peritonitis	2½ days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation: 1/18/49

Major findings of operation: Acute appendicitis with rupture & localized peritonitis

Autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 1/17/49

VS 150

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G70618 ✓ 181 G70618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clemence Wright.

2. DATE OF DEATH: 1-14-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 824 W. Saratoga

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18 01

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 824 W. Saratoga St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	C	Married	8-10-1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Copper Foundry		Eastern Shore, Md.	U.S.A

13. FATHER'S NAME: Robert Wright.

14. MOTHER'S MAIDEN NAME: Janie Moore.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Margaret Wright.	824 W. Saratoga

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of urinary Bladder — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 15 19 48 *to* Jan. 14 19 49 *that I last saw the deceased alive on* Jan. 11 19 49 *and that death occurred at* 1:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	612 Edmondson Ave	1-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	Jan 18, 1949	Sandy Bottom	Jullenanne Co.	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	Mrs Katie R. Williams	322 N. Schroeder St.

52B

151976 ✓X 194 G70619

BIRTH NO. G70619

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Lela Parks

2. DATE OF DEATH: Jan 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Md. - Dalew

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Calvert Co
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Broomis Island
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	1-24-80	68 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Thomas Fowler

14. MOTHER'S MAIDEN NAME: Christine Beverly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of the Thyroid Gland	10 mos.
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Cirrhosis of the liver	about 10-12 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 1-13-, 1949 *to* 1-16-, 1949 *that I last saw the deceased alive on* 1-16-, 1949, *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bertram E. Sprafkin M. D.	JOHNS HOPKINS HOSPITAL	1-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 19 49	Broomes Island Cem	Brooms Island Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	A A Harkness & Son	Mutual Md

VS 150

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670620 ✓ 670620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 022 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HENRY HURTT

2. DATE OF DEATH: 1/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 38 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1132 Comet St 5-01

5. SEX: male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 4-15-79
9. AGE (In years last birthday): 69 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-10-6206
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aneurysm of the arch of the aorta
DUE TO
(B) Syphilis
DUE TO
(C) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas Mallinckrodt M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 1-18-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: ADDRESS: Elroy O. Wilson, 1000 Brantley Rd

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#1 on Wagner G70621 ✓ X193 G70621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Richard Whipp — York Pa. — 2. DATE OF DEATH 1-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland University Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
c. Length of stay in Baltimore 4 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Penna B. COUNTY York
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) York
D. STREET ADDRESS (If rural, give location) 134 Grant St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	married	Oct-16-1896	52	3	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Moulder.	Foundry.	Maryland	Maryland.

13. FATHER'S NAME Richard Whipp. deceased
14. MOTHER'S MAIDEN NAME Ellen Crummett. deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
yes World war. 1	175-10-2032	Sadie Whipp	York Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiorespiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral neoplasm, malignant (over)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
1-15-49	Sub-tentorial tumor - left cerebellar hemis.	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 1-12, 1949, to 1-16, 1949, that I last saw the deceased alive on 1-16, 1949, and that death occurred at 10:50 A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred R. McCrumb Jr. M. D.	University Hospital	1-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removed.	Jan. 17 1949	Prospect Mountain.	York York Co Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	[redacted]	A. F. Keller	York Pa.

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B.C.-48-15 #87 ✓ 085.1

G70622 BALTIMORE CITY HEALTH DEPARTMENT G70622

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) SHARON-ANN-McCORLEY

2. DATE OF DEATH Jan. 15-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 100 S. Mount St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — — — —

C. Length of stay in Baltimore 5 Yrs. 5 Mos. 15 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore city

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 100 S. Mount St 19-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	July 30-1948	—	5	15	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Balto. Md

12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME Leroy E. Mc Carley Jr.

14. MOTHER'S MAIDEN NAME Margaret M. Romm

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

16. SOCIAL SECURITY NO. none

17. INFORMANT Mr. Leroy E. Mc Carley ADDRESS 100 S. Mount St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Measles	2 Wks
DUE TO		
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C) Bronchial Pneumonia	Unknown
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 Jan 19 49 *to* 15 Jan 19 49 *that I last saw the deceased alive on* 1 Jan 19 49 *and that death occurred at* 2 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE Laura B. Thomas M. D. — 23B. ADDRESS 4207 Fredericksburg — 23C. DATE SIGNED 17 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE Jan 18-1949 — 24C. NAME OF CEMETERY OR CREMATORY Cathedral — 24D. LOCATION (City, town, or county) (State) Baltimore City Md

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE [illegible] — 25. FUNERAL DIRECTOR Geo. L. Beyer Jr ADDRESS 1512 Hollins St

VS 150

JAN 17 1949

35

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Rena A. Brauer
2. DATE OF DEATH: Jan 16, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland — St Agnes Hospital
   B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes' Hospital
   C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE
   B. COUNTY
   605 N. Denison St. 16-08
   C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
   D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Divorced	March 23, 1893	55	9	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto. Md.	

12. FATHER'S NAME: Frederick Snyder
14. MOTHER'S MAIDEN NAME: Mary --------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
			Mrs. Virginia Kiessling, 605 N. Denison St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteriosclerotic Cardio-Vascular disease	
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
William L Kelbech M.D.	☐ / ☐ / ☒	1/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Jan. 20/49	Loudon Pk.	3801 Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	Harry N. Nuttle	4101 Edmondson Ave.

VS 191

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70624 Ost 6. State Anatomical ✓ H20.1 G70624

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joe Madonne

2. DATE OF DEATH: JAN 6 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 36 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1020 E Baltimore St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	? ? 1875	73 years		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Italy	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral embolus — (Interval between onset and death): 10 days

DUE TO

(B) Myocardial infarction with — 1 month

DUE TO

(C) Mural thrombus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-28 1948 *to* 1-6 1949, *that I last saw the deceased alive on* 1-6 1949, *and that death occurred at* 7:10 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William D. Stroud M. D.	JOHNS HOPKINS HOSPITAL	1/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	JAN 12 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 11 1949	Huntington Williams, M.D.	Commissioner of Health	

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0625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 670625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 Dolphin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM MOORE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 12 1949
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) JAN 17 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1948, at 9:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/31/48

X

0626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G70626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 4-01
(If outside city or town limits, write RURAL and give town)
(d) Street No. 162 N Hay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Steve

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race XX

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years Aprox 65 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant John Kammer
(b) Address 162 N. Hay St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Johns Hopkins Medical School JAN 12 1949

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 7 1949 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1948, at 9 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18 1948 to 12-19 1948. and that I last saw him alive on 12-19 1948.

Immediate cause of death Cerebro-vascular Accident

Due to Hemiplegia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Mercy Hosp. Date signed 1-7-49

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G70627 ✓ 491 G70627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 330 Rossiter Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 27-11
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 Rossiter Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa M Morrissey ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1871

8. AGE: Years 76 77 | Months | Days | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Michael Morrissey
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary O'Grady
15. Birthplace Ireland

16 (a) Informant Miss Catharine M. Grady
(b) Address 330 Rossiter Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-49 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Phila. Pa.

18 (a) Funeral director John G. Moran
(b) Address 3060 E. Balt. St.

(c) Date received by registrar 1-19-49 (b) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1948 19 49 at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/48 19 to 1/17 19 49
and that I last saw her alive on 1/13/49 19

Immediate cause of death
Acute Cardiac Dilatation — Duration 1 day
Due to
Due to
Other Conditions Bronchopneumonia — 4 days
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature John G. Hamer M.D.
Address 11 E. Chase St Date signed 1/19/49

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

107

Certificate Corrected 1-24-49. ✓ 177 G70628

Dr. Haase

G70628

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): John S. (Sam) Sparks

2. DATE OF DEATH: Jan. 15. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4419 Frankford Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4419 Frankford Avenue 26-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Mar. 16, 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ~~Baltimore, Md.~~ Martinsburg, Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Sparks

14. MOTHER'S MAIDEN NAME: Orbie E. Bowers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-05-4502

17. INFORMANT: Mrs. Martha Sparks, ADDRESS: 4419 Frankford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Prostate metastasis — INTERVAL BETWEEN ONSET AND DEATH: 2½ yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Multiple operations	Operations contributed to abuse	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept. ____, 19 47, *to* Jan. ____, 19 49 *that I last saw the deceased alive on* 1/15, 19 49, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Harry Haase M. D.	4218 Harford Rd.	1/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-18-1949	Mt. Olivet Cem.	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 19 1949	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

51C

Dr. Harbold G70623 ✓ 441 G70629

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Lloyd E. Hanshaw

2. DATE OF DEATH: Jan. 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2800 Bauernwood Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-07
D. STREET ADDRESS (If rural, give location): 2800 Bauernwood Avenue

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: May 31, 1875
9. AGE (In years last birthday): 73 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Anne Arundel Co, Md.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. F. Russell, 2800 Bauernwood — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis with Myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH: 10 years

DUE TO

(B) Malignant hypertension

DUE TO

(C) Arteriosclerosis & pyelonephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Terminal uremia

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 20, 1946 *to* Jan 15, 1949 *that I last saw the deceased alive on* Jan 14, 1949 *and that death occurred at* 8:15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. V. Harbold M. D.
23B. ADDRESS: 4706 Harford Road
23C. DATE SIGNED: 1-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-19-49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1949
REGISTRAR'S SIGNATURE: Curtis for Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Leonard J. Ruck, 5305 Harford Road.

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✓ 420.0

G70630 BALTIMORE CITY HEALTH DEPARTMENT 443 67000

BIRTH NO. MAURER

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Maurer, Mr. William

2. DATE OF DEATH 1-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2607 East Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	Jan. 31-1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Self-Emp	Grocery Man	Germany	

13. FATHER'S NAME ?
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mr. W. Maurer	2520 Rolt St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema
DUE TO Hypertensive Arteriosclerotic C.V. Disease
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-15 19 49, *to* 1-16 19 49, *that I last saw the deceased alive on* 1-16 19 49, *and that death occurred at* 9:00 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Orrie R Mausenger M. D.	University Hospital	1-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-20-49	Parkwood	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Huntington Williams, M.D.	L. J. Luck	5305 Harford

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B.C. 48-02166 ✓ 085.1

G70631

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70631

BIRTH NO.

1. NAME OF DECEASED (Type or Print)	PHILLIP	BROWN	2. DATE OF DEATH January 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 411 West Biddle Street 11-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	colored		Jan 24 1948		11			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Horace Brown	Mildred Morgan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Horace Brown	411 W. Biddle St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

(B) Measles

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil L Beyer M.D.		January 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/18/49	Mt Calvary Cem	R. R. Co

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
JAN 17 1949	Funeral from Williams, Mott	Rayner Sanders	1412 E Preston

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G70632 ✓ X 420.1 G70632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 16 days
(e) Length of stay in Baltimore (yrs., mos., or days): 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: NY (b) County: Long Island
(c) City or town: Laurelton
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 134-44 230th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: JOHN JOSEPH MANDERS

3 (b) If veteran, name war: -
3 (c) Social Security Account No.: -

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec. 10, 1886
8. AGE: Years: 62 Months: 1 Days: 6 If less than one day: hr. min.
9. Birthplace: NYC (Town, county, and state)
10. Usual Occupation: Steward
11. Industry or business: Seafarer

FATHER
12. Name: Simon Manders
13. Birthplace: NYC

MOTHER
14. Maiden Name: Mary ?
15. Birthplace: NYC

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 1 1/17/49 (month) (day) (year)
(c) Cemetery or crematory: St. John's
Location: Middle Village, Long Island, N.Y.
18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JAN 17 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 16 19 49 at 8:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 19 48 to Jan. 16 19 49, and that I last saw him alive on Jan. 16 19 49

Immediate cause of death	Duration
1- Arteriosclerotic heart disease	Unknown
Due to 2- Coronary thrombosis, old	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed: 1/17/49 M.D.

Please write plainly. Physicians: please write the causes of death clearly and legibly. Underlining the cause to which death is charged statistically is especially important

G70633 ✓ 422.1 G70633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARTIN HACKER

2. DATE OF DEATH: 1/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gardenville Convalescent Home

C. Length of stay in Baltimore: 45 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 220 N. Madeira Street 603

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widowed	Nov. 11, 1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		Czechoslovakia	America

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT — ADDRESS: Mrs. Sophia Kolomaznik, 805 N. Curley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

(B) Myocardial degeneration

DUE TO

(C) Arteriosclerosis, hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Lupus erythematosis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 5, 1949 *to* Jan 15, 1949 *that I last saw the deceased alive on* Jan 14, 1949, *and that death occurred at* 3:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. H. Harbold M. D.	4706 Harford Road	1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/19/49	Oak Hill Cemetery	Horner's Lane, Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 19 1949	Thurlington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street

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937

G70634 ✓ 723.0 420.1 G70634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY ZANG

2. DATE OF DEATH: Jan. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1119 Wilmot Court
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1119 Wilmot Court

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Dec. 22, 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife			

13. FATHER'S NAME: Anton Horak

14. MOTHER'S MAIDEN NAME: Barbara Senger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Mrs. Marie Falk, 1119 Wilmot Court

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis

DUE TO

(B) Ch Hypertension

DUE TO

(C) Ch arthritis (Hypertrophic)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/9, 19__, *to* 1/13, 1949 *that I last saw the deceased alive on* 1/13, 1949, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. H. Hornstein M. D.	204 E. Biddle St	1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/18/49	Oak Lawn	Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 17 1949	[illegible] Baltimore, Md.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street

VS 150

94a

0635 153 G70635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MRS. Ruby C Heise

2. DATE OF DEATH: 1-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union memorial Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore -
D. STREET ADDRESS (If rural, give location): 4424 Belle Hall Road 27 09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	married	9-27-1898	50	3	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Emory Carpenter
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Murdock
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: Hospital Records -

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of sigmoid & metastases
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH: at Best 11-12 —

19A. DATE OF OPERATION: 9-15-48
19B. MAJOR FINDINGS OF OPERATION: Inoperable Carcinoma of Sigmoid
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/21, 1948 *to* 1/17, 1949 *that I last saw the deceased alive on* 1/17, 1949 *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: James McC. Finney M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 1-17-49

24A. BURIAL, ~~CREMATION~~ REMOVAL (Specify): Burial
24B. DATE: Jan 20th 1949
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Wm Cook Inc. 1217 St. Paul St.

VS 150

46E

G70636 ✓X 754.4 G70636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Baughess Philip Bacle

2. DATE OF DEATH Jan. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Hosp. Hosp. Hal. 3

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. 2 Mos. 7 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Florida
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Key West
D. STREET ADDRESS (If rural, give location) 107 D Pomeriana

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Child	7-1-39	9 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Cuba	

13. FATHER'S NAME Peter Bacle

14. MOTHER'S MAIDEN NAME Mary Solomon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cyanotic Congenital heart disease — INTERVAL BETWEEN ONSET AND DEATH: Birth

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Tricuspid atresia

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cardiac failure

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
11/27/48	Pulmonary stenosis	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-25-, 1948 *to* 1-17-, 1949 *that I last saw the deceased alive on* 1-17-, 1949 *and that death occurred at* 10:05 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry T. Johnson M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	Jan 18th 1949	Green Mount	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Wm Cook Inc.	217 St. Paul St.

VS 150

157E

G70637 ✓ 422.1 G70637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): John W. Knight
2. DATE OF DEATH: 16 Jan. 49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 408 E. North Ave 12-04
5. SEX: Male
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: 9/22/1873
9. AGE (In years last birthday): 75
If Under 1 Year: Months 3 Days 24
If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telegrapher
10B. KIND OF BUSINESS OR INDUSTRY: B. & O. R.R.
11. BIRTHPLACE (State or foreign country): Magnolia Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John W. Knight
14. MOTHER'S MAIDEN NAME: Benenna Godwin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Gertrude Knight ADDRESS: 408 E. North Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardio-Vascular Disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer, D. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 16 Jan. 49

24A. BURIAL, CREMATION, REMOVAL (Specify): 24B. DATE: 1/19/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Abingdon M.E. Church Cem
24D. LOCATION (City, town, or county) (State): Harford Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 E. Paul St.

VS 151

937

G70638 ✓ 416 G70638

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): LOUIS J. KOERNICKE

2. DATE OF DEATH: Jan. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1747 N. Chester St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1747 N. Chester St. 8-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Sept. 11, 1894	54	4	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Caulker	City of Baltimore	Washington, D.C.	

13. FATHER'S NAME: Charles Koernicke

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	World 1	None	Mrs Ella M. Koernicke	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

DUE TO

(B) Rheumatic C-V Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Dec. 28, 1948 *to* Jan. 16, 1949 *that I last saw the deceased alive on* Jan. 15, 1949 *and that death occurred at* 7:30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. H. Krenzer M. D.	1402 E. Lanvale St.	1-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/20/49	National	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	William Cook, Inc.,	1217 St. Paul St.

VS 150

93c

70639 ✓ 420.0 443 G70639

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Bertha Chamish
2. DATE OF DEATH: 1/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General
C. Length of stay in Baltimore: 27 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3916 Fernhill ave 15 10

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 70
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David
14. MOTHER'S MAIDEN NAME: Dula

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bessie Kerner ADDRESS: 3916 Fernhill Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO
(B) Hypertensive Arterio-sclerotic heart disease — 20 mos +
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/17, 1949 *to* 1/18, 1949 *that I last saw the deceased alive on* 1/13, 1949 *and that death occurred at* 4:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: D. P. Young, M. D.
23B. ADDRESS: West Balto Gen Hosp
23C. DATE SIGNED: 1/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-20-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county): Balto
(State): Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

937

G70640 ✓ 443 G70640

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MAX FEINSTEIN

2. DATE OF DEATH: 1/17/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp.

C. Length of stay in Baltimore: 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto., Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3913 Spaulding Ave 27-18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married		64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant	Hardware	Russia	

13. FATHER'S NAME: Hesr

14. MOTHER'S MAIDEN NAME: Shana

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Rebecca Feinstein 3713 Spaulding Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular accident — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) HCVD — DUE TO

(C) — DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/13, 1949, *to* 1/17/49 19__, *that I last saw the deceased alive on* 1/17/49 19__, *and that death occurred at* 8:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lee N. Kastner, M.D.	3913 Spaulding Ave	1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-18-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Jack Lewis Jr.	2100 Eutaw Pl

VS 150

937

✓ 420.0

G70641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G70641 Registered No.

1. NAME OF DECEASED (Type or Print) Goldberg Mrs Anna

2. DATE OF DEATH 1-16-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-18

c. Length of stay in Baltimore 40 Yrs. / Days

D. STREET ADDRESS (If rural, give location) 4450 Narcissus Ave

6. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married		58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Russia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Velva	Bula

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Samuel Goldberg - 4450 Narcissus Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

(B) Arteriosclerotic C.V. disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic hypertrophic Leukemia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-16 1949 *to* 1-16 1949 *that I last saw the deceased alive on* 1-16 1949 *and that death occurred at* 10 55P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Calvin R Hausknecht M. D.	University Hospital	1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-18-49	Adas Israel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eastern Ave

VS 150 --

74a

70642 ✓ 550.1 G70642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Michael, Webster

2. DATE OF DEATH: 1/16/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1519 Division Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 736 George Street 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Single	8/25/34	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Baltmore, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Michael

14. MOTHER'S MAIDEN NAME: Ines Sterling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Generalized Peritonitis	
DUE TO		
(B)	Ruptured Appendiceal Abscess	
DUE TO		
(C)	Ruptured Appendix	

19A. DATE OF OPERATION: 1/16/49

19B. MAJOR FINDINGS OF OPERATION: Generalized Peritonitis

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/15 1949 *to* 1/16, 1949, *that I last saw the deceased alive on* 1/16, 1949, *and that death occurred at* 1060A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Dr Marcus W. Moore Sr M. D.

23B. ADDRESS: Provident Hospital

23C. DATE SIGNED: 1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/21/49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Autumn.

24D. LOCATION (City, town, or county) (State): West Port Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Mehrfeldstein Funeral Home Inc. 927 N. Mount St.

VS 150

121

70643 ✓ 331 G70643

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): BERTHA LEHMAN.

2. DATE OF DEATH: 1/16/49.

3. PLACE OF DEATH: A. Baltimore City, Maryland 2476 Shirley Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt. Carmel Nursing Home.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): Temple Garden Apts. 13-01

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced.
8. DATE OF BIRTH: Nov. about 1868
9. AGE (In years last birthday): about 80 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kentucky.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Wile
14. MOTHER'S MAIDEN NAME: Caroline Straus.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mr. Dolphe Wile. ADDRESS: Lexington, Ky.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	Nov 8 '48 - 2 mos
DUE TO (B)	Arterio-sclerosis & hypertension	5 yrs
DUE TO (C)	Acute dilatation of heart. (oedema of lungs)	1 day
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: ✓
19B. MAJOR FINDINGS OF OPERATION: ✓
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ✓
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): ✓
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): ✓
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.: ✓
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur? ✓

22. *I hereby certify that I attended the deceased from* Nov 8 19~~48~~ *to* Jan 16 19~~49~~, *that I last saw the deceased alive on* Jan 14 19~~49~~, *and that death occurred at* 8 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: I. Frederick Lerch M. D.
23B. ADDRESS: Temple Garden Apts.
23C. DATE SIGNED: 1/17/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/49.
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Hebrew
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR AND ADDRESS: David Sondheim & Son. 1902 Eutaw Place.

VS 150

83a

0644 ✓ 420.1 G70669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mary Elizabeth Parlett
2. DATE OF DEATH: Jan-16-49
3. PLACE OF DEATH: A. Baltimore City, Maryland 2924 Westwood
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at Home
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY Balto City C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2924 Westwood Av 15-06
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: July-20-1875
9. AGE (In years last birthday): 73 yrs (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Benj. J. Parlett
14. MOTHER'S MAIDEN NAME: Anne Louisa Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mary E. Parlett (wife) ADDRESS: 2924 Westwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 Hr

DUE TO

(B) Coronary arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Indefinite

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 16 Jan 1949 to 16 Jan 1949 that I last saw the deceased alive on 16 Jan 1949 and that death occurred at 11 30 P m., from the causes and on the date stated above.

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 2020 N. Charles St
23C. DATE SIGNED: 17 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan-19-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Olivet
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Stewart & Mann Company ADDRESS: 94a Baltimore

VS 150

G70645 ✓ 170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70645 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary B. Crowl

2. DATE OF DEATH: 1-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Ambassador Apartments 12-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	9-17-72	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Jerry Baden

14. MOTHER'S MAIDEN NAME: Rebecca Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: William Caspari, Jr. ADDRESS: Baltimore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intestinal Obstruction
DUE TO
(B) Carcinoma of breast & metastases
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [✓] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-30, 1948, *to* 1-15, 1949, *that I last saw the deceased alive on* Jan 15, 1949, *and that death occurred at* 9:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Frank Snyder III M. D.

23B. ADDRESS: Union Memorial Hosp

23C. DATE SIGNED: Jan 15 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-18-49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Stewart & Mowen Company ADDRESS: Baltimore

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50

0646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 20646

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DOA
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md 6-05
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Pricker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School JAN 6 1949

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 18 1949 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1948, at 10:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. A. Helwig M.D.
Medical Examiner.
Date signed 12/26/48

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correct age is especially important. Physicians, please write the cause of death plainly.

0647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. G70647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D-6A
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 W Fayette St
(If rural give location)
(e) Citizen of foreign country? 18-0 (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Sabuda

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 5 1949

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 18 1949 for Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1948, at 1 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. G. Schmidt M.D.
Medical Examiner.
Date signed 12/25/48

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X

0648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G70648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7hrs. 20min.
(e) Length of stay in Baltimore (yrs., mos., or days) 18-03

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 W. Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY GREEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation UNKNOWN
11. Industry or business

FATHER 12. Name U
13. Birthplace N

MOTHER 14. Maiden Name K N
15. Birthplace O

16 (a) Informant W
(b) Address N

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 6 1949

18 (a) Funeral director Commissioner of Health
Address JAN 18 1949

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1948, at 5:30 AM

21. I certify that I took charge of the remains described above, held an Insp.& Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage (spontaneous)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 12-22-48 DJM

70649
Dr. Gonzales

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

241 G70649
BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): William James Farrell
2. DATE OF DEATH: Jan. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3309 Lerch Drive
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3309 Lerch Drive 27-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	widowed	Mar. 14, 1871	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Rhode Island	

13. FATHER'S NAME: William J. Farrell
14. MOTHER'S MAIDEN NAME: Catherine Flynn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Mr. T. J. Farrell,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Right sided failure c pulmonary hypertension — DUE TO
(B) Chronic toxic alimentation — DUE TO
(C) Hypostatic pneumonia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 week.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 10th, 1949, *to* Jan 15, 1949 *that I last saw the deceased alive on* Jan 15, 1949 *and that death occurred at* 11:20 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. E. Gonzales M.D. M. D.	5304 Harford Road.	Jan 17 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-18-49	New Cathedral	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

112

B.C.48-27731 ✓ 754.4

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 2731 Registered No. 070650

1. NAME OF DECEASED (Type or Print): Margaret Lilanskas
2. DATE OF DEATH: JAN 17 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18 03; D. STREET ADDRESS (If rural, give location): 44 S Poppleton St
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 12-21-48
9. AGE (In years last birthday): Under 1 Year: Months 1; Days; Under 24 Hours: Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Edward Lilanskas
14. MOTHER'S MAIDEN NAME: Lillian Zolinas
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

a. Length of stay in Baltimore; Yrs. Mos. Days

3B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CONG. MALFORMATION OF HEART — INTERVAL BETWEEN ONSET AND DEATH: 27 DAYS
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-17-49 to 1-17-49, *that I last saw the deceased alive on* 1-17-49, *and that death occurred at* 10:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Elan C. Hermann M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-19-48
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 901 Hollins

VS 150

1576

G70651 ✓ 420.0 G70651

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Ella L. Welch

2. DATE OF DEATH: January 16, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore, Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: 3 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2827 N. Calvert St. 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	March 28, 1862	86 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	

13. FATHER'S NAME: George P. Steinbach

14. MOTHER'S MAIDEN NAME: Caroline Bruehl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mr. George P. Welch-159 N. Central Ave.	Long Island N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure
DUE TO
(B) Cardiac Failure
DUE TO
(C) Arterio sclerotic Heart Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 13, 1947, 19__, *to* June 16, 1948, *that I last saw the deceased alive on* Jan 16, 1949, *and that death occurred at* 1 PM., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip G. Peter M.D. M.D.	1400 N Caroline St.	Jan. 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	1/19/49	Greenmount Crem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Temporary for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150-A

937

✓ 444

G70632

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70632

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Francis M. Burke.

2. DATE OF DEATH: 1/16/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2537 Robb St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.

c. Length of stay in Baltimore: Yrs. Life. Mos. Days

D. STREET ADDRESS (If rural, give location) 2537 Robb St. 9-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male.	White	Married.	10/10/1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman, Retired	Nexema Co.	Maryland.	

13. FATHER'S NAME: Francis M. Burke.

14. MOTHER'S MAIDEN NAME: Jennie Porter.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	-	215-03-4212	Angela E. Valenza	2537 Robb St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Duodenal Ulcer — Interval between onset and death: 3 hrs

DUE TO

(B) Multiple Hemorrhages Secondary to — 2 days

DUE TO

(C) Hypertension & Arteriosclerosis — 3 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 15, 1949, to January 16, 1949, *that I last saw the deceased alive on* Jan 16, 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. P. A. Stevens M. D.	2818 Harford Rd	1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/19/49	St Mary's	Govans

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Paul E. Chenoweth Jr.	3615-17 Chestnut Ave.

VS 150

920

✓ 151

70653

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70653

1. NAME OF DECEASED (Type or Print): John Elmer Montgomery

2. DATE OF DEATH: January 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR [redacted] (If not in hospital or institution, give street address or location): St. Joseph's

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1346 N. Washington 807

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 25th, 1884

9. AGE (In years last birthday): 64 yr.
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: Unemployed

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John E. Montgomery

14. MOTHER'S MAIDEN NAME: Emma Greene

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 220-09-3803

17. INFORMANT: Mrs Montgomery ADDRESS: 1346 N. Washington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gastro-intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO

(B) Ulcerative Carcinoma of stomach — ?

DUE TO

(C) C metastases to liver and spleen

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 8, 1949 *to* Jan. 16, 1949, *that I last saw the deceased alive on* Jan. 16, 1949, *and that death occurred at* 12:20 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: E. Joseph Kieji M. D.

23B. ADDRESS: 1400 N. Caroline St.

23C. DATE SIGNED: Jan. 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 19th 1949

24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn

24D. LOCATION (City, town, or county) (State): Eastern Ave East

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Leo G. Snoke ADDRESS: 1703 N. Patterson Park Ave.

VS 150

46B

Certificate Corrected 1-21-49. ✓

G70654 — BALTIMORE CITY HEALTH DEPARTMENT — 154 — G70654

BIRTH NO — **CERTIFICATE OF DEATH** — Registered No.

1. NAME OF DECEASED (Type or Print): MRS. Georgie Bell
2. DATE OF DEATH: 1/16/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp. Inc.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md
b. COUNTY: 1823 N Mount Ford Ave
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
d. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W	Oct 23 1887 (1882)	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	

13. FATHER'S NAME: Henry Ziegler
14. MOTHER'S MAIDEN NAME: Margaret Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Generalized Carcinomatosis	
	DUE TO	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	over
	DUE TO	
	(C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 14 1949 *to* Jan 16, 1949 *that I last saw the deceased alive on* Jan 16, 1949 *and that death occurred at* 7 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph L. Grante M. D.	Mercy Hosp.	1/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Jan 20 1949	Oak Lawn	Eastern Ave Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Leo G. Cook	1701-03 E Pattersn Park Ave

VS 150

467

G70655 BIRTH NO. B.C. 49-03739

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70655

1. NAME OF DECEASED (Type or Print): BABY HEUER

2. DATE OF DEATH: January 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1925 N. Castle Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1925 N. Castle Street 8-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	White		Jan 17th 1949					15?

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: [illegible]
14. MOTHER'S MAIDEN NAME: Mary Heuer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Suffocation
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1925 N. Castle Street
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: January 17, 1949 p.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Suffocated in toilet bowl

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: Earl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Jan 18th 1949	Oak Lawn	Eastern Ave Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leo G. Leach ADDRESS: 1703 N. Patterson Park Ave

VS 151

168

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 916.D N 949

Registered No. 70656 (70656)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
20-07
(d) Street No. 3431 Edmondson ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mamie H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1868

8. AGE: Years 80 | Months 7 | Days 17 | If less than one day: hr. min.

9. Birthplace Georgia (town, county, and state)

10. Usual Occupation Baker's Helper

11. Industry or business Koester Bake Co.

FATHER
12. Name James A. Richardson
13. Birthplace Georgia

MOTHER
14. Maiden Name Rebecca Hart
15. Birthplace Georgia

16 (a) Informant Mrs R. Rogers
(b) Address 38 S. Arlington ave

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Jan 19 1949 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Walker Blvd Elkridge

18 (a) Funeral director Frederick A. Cott
(b) Address 1500 W Lombard St

19 (Signature and address of local registrar) JAN 18 1949 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1949 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1949 to Jan 15 1949 and that I last saw him alive on Jan. 15 1949.

Immediate cause of death Cardiac Failure — Duration

Due to Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions 2nd & 3rd degree burns over 1/3 of body (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

CERTIFICATION APPROVED BY John R. Davis per Abe Merrill CHIEF OR ASST. MEDICAL EXAMINER

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20-7
(a) Accident, suicide, or homicide 2nd & 3rd° burns
(b) Date of occurrence Jan. 1 1949 at 7A M
(c) Where did injury occur? Baltimore (City or town) (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No
(e) Means of injury Fire Accidental. House afire.

23. Signature Daniel Rubenstein, M.D.
Address West Balto Gen. Hosp. Date signed 1/15/49

180

VS 191

G70657 — 442 — G70657

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. — Registered No. G70657

1. NAME OF DECEASED (Type or Print): Sam Bell

2. DATE OF DEATH: Jan. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 534 Robert St.
c. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 534 Robert St.. 14-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	C	Married	2-9-1910	38	11	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer Sugar Refinery		Elberton, Ga..	U.S.A.

13. FATHER'S NAME: Tom Bell..

14. MOTHER'S MAIDEN NAME: Irene ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Annie Bell. ADDRESS: 534 Robert St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr?

DUE TO —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 2, 1949, *to* Jan 17, 1949, *that I last saw the deceased alive on* Jan 16, 1949, *and that death occurred at* 9:31 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr. William Frey M. D.	1928 Penna Ave	1/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/20/1949	Arbutus Memorial	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, Clerk	Clare Kate R. Williams & Schroeder	322

VS 150

1312

G70658 ✓ 002 G70658

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE OLIVER

2. DATE OF DEATH: 1/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1845 Lorman St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 20 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1845 Lorman St 15-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Married	11/22/1907	41	1 / 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hod Carrier	Construction	Kingstill, S.C.	U.S.A.

13. FATHER'S NAME: George Oliver

14. MOTHER'S MAIDEN NAME: Charlotte Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	-	

17. INFORMANT: Eileen Oliver ADDRESS: 1845 Lorman St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculosis of Lungs
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 7, 19 49, *to* Jan 14, 19 49 *that I last saw the deceased alive on* Jan 11, 19 49, *and that death occurred at* 9.45 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William Frey M. D.	1928 Penna Ave	1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/18/49	Mt. Auburn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 18 1949	Huntington Williams, MD	Charles G. Cooper-512N. Carrollton Av

VS 150

13B

G70659 ✓ 416 G70659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Ada Elizabeth Rock

2. DATE OF DEATH: Jan. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3217 Baker St.,

c. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3217 Baker St., 16-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed	April 25, 1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Frederick Drinkwater

14. MOTHER'S MAIDEN NAME: Elizabeth Harrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Theodore F. Rock ADDRESS: 905 Woodington Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemmorhage	acute
DUE TO (B)	Arterio Sclerosis - Hypertension	10 yrs
DUE TO (C)	Rheumatic Heart disease.	over 20 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1, 1937 *to* Jan 3/45, 19..., *that I last saw the deceased alive on* Jan 17, 1949, *and that death occurred at* 1:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jack N Zierler M. D.

23B. ADDRESS: 2318 Eutaw Place

23C. DATE SIGNED: 1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-20-49	Lorraine Park	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: D. Howard Strong ADDRESS: 3207 W. North Ave.

VS 150

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G70660 ✓ 422.1 G70660

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Emma O. Lanahan

2. DATE OF DEATH: Jan. 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3023 W. North Ave., 15-06

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Crawford Nursing Home 2117 Denison St.

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Divorced	July 7, 1871	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Norfolk, Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Willoughby Nicholas

14. MOTHER'S MAIDEN NAME: Zena Sweeting

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO:

17. INFORMANT: Mr. George W. Green ADDRESS: 506 Allendale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility & Arteriosclerosis — DUE TO

ANTECEDENT CAUSES

(B) Uremia — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Myocarditis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: none

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): no

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): no

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: no

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? no

22. *I hereby certify that I attended the deceased from* Nov 12 1948 *to* Jan 16, 1949 *that I last saw the deceased alive on* Jan 16, 1949 *and that death occurred at* 11 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: M.P. Byerly M. D.

23B. ADDRESS: 3033 W North Ave

23C. DATE SIGNED: 1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-19-49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: G. Howard Strong ADDRESS: 3207 W. North Ave.

VS 150

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G70661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

Registered No. G70661

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN J. SKARDA

2. DATE OF DEATH: Jan. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Colonial Nursing Home

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 906 N. Milton Avenue

7-0-7

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Jan. 13, 1883
9. AGE (In years last birthday): 66
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?: no

13. FATHER'S NAME: John Skarda
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: James J. Skarda, ADDRESS: 907 N. Linwood Ave.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH: 12 Hrs.

DUE TO

(B) Cardiac Failure & Uremia

DUE TO

(C) Hypertensive Cardio Vascular D. Dis — 4 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-10-49, 19__, *to* 1-14, 1949, *that I last saw the deceased alive on* 1-14, 1949, *and that death occurred at* 7P m., *from the causes and on the date stated above.*

23A. SIGNATURE: William L. Fearing M.D.
23B. ADDRESS: 3025 Belair Road
23C. DATE SIGNED: 1-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/18/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): 4430 Belair Rd., Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Schmunck Funeral Home, Inc. 2601-3 E. Madison Street

937

G70662 Pollhammer 414 G70662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Anna Pollhammer

2. DATE OF DEATH 1-18-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore — Yrs. life Mos. Days 7-0

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2425 E. Eager Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
♀	wh	M	May 5, 1906	42				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	

13. FATHER'S NAME: Frederick Boeddeker

14. MOTHER'S MAIDEN NAME: Catherine Berger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	Rudolph Pollhammer	2425 E. Eager St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) RHEUMATIC HEART DISEASE

DUE TO CHRONIC CONGESTIVE

(C) FAILURE - Poss. Mb cardiac cause

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Malnutrition, uremia deficiency anemia

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 15, 1949, *to* Jan 18, 1949, *that I last saw the deceased alive on* Jan. 17, 1949, *and that death occurred at* 1 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm Silverstein M. D.		

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/21/49	Baltimore Cemetery	North Ave. & Rose St.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601 E. Madison Street

VS 150

95B

G70663 ✓ 260 G70663

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Eva Ulatowski

2. DATE OF DEATH: Jan. 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1613 Cereal St. 25-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	married	Aug. 28, 1893	55	4	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
house wife		Poland	

13. FATHER'S NAME: Joseph Klowsiakeika

14. MOTHER'S MAIDEN NAME: Mary Lisiakoro

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 160-16-2711

17. INFORMANT — ADDRESS: Alexander Ulatowski 1613 Cereal St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Diabetes Mellitus	4 yrs.
DUE TO	chron. fibroid Tb Lungs	?
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1. 12, 19 49 *to* 1. 15, 19 49 *that I last saw the deceased alive on* 1. 15, 19 49 *and that death occurred at* 6 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry J. Summers M. D.	1045 Reisterstown Road	1. 15. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-20-49	Holy Cross	Ritchie Hghy.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Clarence F. Hoffmann 1639 Broadway.

13B

G70664 ✓ 420.1 G70664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Geo. M. Schroeder
2. DATE OF DEATH: Jan 16/49
3. PLACE OF DEATH: A. Baltimore City, Maryland 6531 Balto Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE 6531 Balto Ave B. COUNTY 26 06
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 6531 Balto Ave
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 3/878
9. AGE (In years last birthday): 70 — If Under 1 Year: Months 11, Days 13 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Louis A. Schroeder
14. MOTHER'S MAIDEN NAME: Catherine Traeger
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: Louisa Schroeder
ADDRESS: 6531 Balto Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Sclerosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/16, 1949 *to* 1/16, 1949 *that I last saw the deceased alive on* 1/16, 1949 *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles H. Flohr M. D.
23B. ADDRESS: 3123 Eastern Ave
23C. DATE SIGNED: 1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 20/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: Courtenay Williams, M.D.
25. FUNERAL DIRECTOR: Philip Henry Sons
ADDRESS: 2024 Orleans St

VS 150

94a

G70665 Vol 5 ✓163 G70665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John Fratila

2. DATE OF DEATH JAN 15 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4823 Wright Ave 21-34

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	5-10-89	59	8 / 3	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Austria

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Fratila

14. MOTHER'S MAIDEN NAME ? ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 213-09-2369

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lung, left. — INTERVAL BETWEEN ONSET AND DEATH: At least 8 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) None

DUE TO

(C) None

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 12-31 1948 *to* 1-15 1949, *that I last saw the deceased alive on* 1-15 1949, *and that death occurred at* 7:42 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Cancel D. Foss M. D.	JOHNS HOPKINS HOSPITAL	1-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Jan 19/49	Oak Lawn Cem	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR JAN 18 19[illegible]

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Philip Herwig Sons

ADDRESS 3029 Eastern Ave

VS 150

471

G70666 Handschuh ✓ 480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G70666 Registered No.

1. NAME OF DECEASED (Type or Print): Mary Handschuh

2. DATE OF DEATH: Mon. January 17, 1949 - 12:05 P.M.

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1448 Patapsco St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.

c. Length of stay in Baltimore: About 60 yrs. (Yrs. Mos. Days)

D. STREET ADDRESS (If rural give location): 1448 Patapsco St. 25 05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married -	Sept. 22, 1865	83 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife -		Bavaria, Germany	U.S.

12. FATHER'S NAME: John Guethlein

14. MOTHER'S MAIDEN NAME: ? ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No -

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. (217-24-2536-B)

17. INFORMANT (Husband) John Handschuh - ADDRESS 1448 Patapsco St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute bronchopneumonia (following influenza) — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypertensive cardiovascular disease — 2 ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/7, 1949, *to* 1/17, 1949, *that I last saw the deceased alive on* Jan 17, 1949, *and that death occurred at* 12:5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Baiese M. D.	1226 Hanover St.	1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Thurs. Jan. 20, 1949	London Park Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: GIVEN REGISTRATION NO.

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: A. Howard Evans — ADDRESS: 1400 S. Charles St. Baltimore 30, Md.

VS 150

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G70667 ✓ 422.1 G70667

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Antonio Cella

2. DATE OF DEATH: Jan 16-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 511 Albemarle St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 49 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 511 Albemarle St 3 02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	White	Married	July 18 1861	87	6	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Italy	U.S.A.

13. FATHER'S NAME: Christopher L. Cella

14. MOTHER'S MAIDEN NAME: Anna Maria Belli

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Marie Cella ADDRESS: 511 Albemarle St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) General Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO

(B) Chronic Myocarditis — 5 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 13, 1947 *to* Jan 16, 1949, *that I last saw the deceased alive on* 1/16/49, *and that death occurred at* 5:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Milton L. Solomon M. D.	129 S. Broadway	1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-20-49	Holy Redeemer	4600 Belair Rd. Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Riggal Bros.	1800 E. Lombard St

VS 150

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Bergmann Otto

2. DATE OF DEATH: Jan 16 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Franklin Square Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore: 37 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 4413 Parkmont Ave 76-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Fe	W	Married	May 14 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Adolph Zeinog
14. MOTHER'S MAIDEN NAME: Matilda Kalres
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Edmund Bergmann ADDRESS: 4415 Parkmont Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetes Mellitus
DUE TO Cerebral Hemorrhage.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-15 *1949, to* 1-16 *, 1949 that I last saw the deceased alive on* 1-16 *, 1949 and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Dr. L. J. Finkell M. D.
23B. ADDRESS: Franklin Square Hosp.
23C. DATE SIGNED: 1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1-19-49.
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lasocka Funeral Home ADDRESS: 7101 Belair Rd.

VS 150

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G70669 ✓ 410 G70669

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) JEFFERSON DAVIS CAMPER
2. DATE OF DEATH JAN 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3438 Edmondson Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	Married	Sept 5 1879	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Candy.	Baltimore Md.	US

13. FATHER'S NAME Jefferson Camper
14. MOTHER'S MAIDEN NAME Georgeanna Evans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic cardiovascular disease
DUE TO Mitral stenosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C) Terminal basilar pneumonia
Pneumothorax, left

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 15 1949 *to* Jan 16 1949, *that I last saw the deceased alive on* Jan 16 1949, *and that death occurred at* 1:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
I. Sirinski M. D.	Mercy Hospital	Jan 16 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 19th 1949	Loudon Park Cem	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	J. Ellis Amoreau	4510 Liberty Heights Ave

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✓ 610

G70670

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70670

1. NAME OF DECEASED (Type or Print): PHILIP J. FURLONG
2. DATE OF DEATH: 1/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital, Calvert & Saratoga Sts.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2228 N. Calvert St. #18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	3/7/1865	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Keystone Auto Clinic	Balto., MD.	U.S.A.

13. FATHER'S NAME: Walter Furlong
14. MOTHER'S MAIDEN NAME: Anastasia Moran

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Marie Furlong ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia
DUE TO
(B) Heart Failure — Arteriosclerotic Heart Disease
DUE TO
(C) Benign Prostatic Hypertrophy

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
suprapubic cystatomy

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/11/49	Suprapubic cystatomy - BPH.	YES ☐ NO ☐

21A. ACCIDENT? SUICIDE? HOMICIDE? (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/27, 1948 *to* 1/17, 1949, *that I last saw the deceased alive on* 1/17, 1949, *and that death occurred at* 2:32 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert E. Enson, M. D.	Mercy Hospital	1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-20-49	St. Mary's Cem. Govans	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wiedefeld & Son: ADDRESS: Greenmount & 22nd St.

VS 150

937

✓ 175(?)

Dr. Brennan

67067 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67067

1. NAME OF DECEASED (Type or Print): Minnie B. Phillips

2. DATE OF DEATH: Jan. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2811 Kildaire Drive
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2811 Kildaire Drive 2707

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	widowed	Mar. 14, 1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Ohio	

13. FATHER'S NAME: Isaac Harris

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Family,	2811 Kildaire Drive #14

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma with pleural effusion and ascites — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B) Embryonal Cell Carcinoma (probably ovary as originate)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept, 1947, *to* Jan 17, 1949, *that I last saw the deceased alive on* Jan 15, 1949, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas J. Brennan M. D.	5217 Harford Road	1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-21-49	Washington Cem.	Washington, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Tuttington Williams, M.D.	L. J. Ruck,	5305 Harford Road #14

VS 150

49a

G706.72 ✓ 174 G706.72

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): H. Genevieve Bandel

2. DATE OF DEATH: January 17 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 6202 Smith Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md. B. COUNTY Balt.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-15
D. STREET ADDRESS (If rural, give location) 6202 Smith Ave not Wash.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married	March 27 1895	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or Foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Cleaning & Dyeing	Baltimore, Md.	

13. FATHER'S NAME: Dennis F. Starr

14. MOTHER'S MAIDEN NAME: Katherine Holland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	TERMINAL PNEUMONIA	2 WEEKS
DUE TO (B)	CARCINOMA, METASTATIC, OF STOMACH, LIVER, INTESTINES	5 MONTHS
DUE TO (C)	CARCINOMA OF UTERUS	7 MONTHS

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE —

CERTIFICATION APPROVED BY H. B. Morrill M.D.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	For: Wm. G. Helfrich M. D. CHIEF OR ASST. MEDICAL EXAMINER	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NONE	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
NONE m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased* from Jan 17, 19 49, to Jan 17, 19 49, ~~that I last saw the deceased alive on ____, 19__~~, *and that death occurred at* 6:58 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Randolph H. Smithberg M.D.	5010 Dunmore Ave	Jan 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Jan 19/49	Druid Ridge	Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Loring Byers

VS 150

48 B

G70673 BAYER ✓ 420.1 G70673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Jacob Bayer

2. DATE OF DEATH: 16 Jan. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 330 S. Bouldin St.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto - 26 10
D. STREET ADDRESS (If rural, give location): 330 S. Bouldin Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	married	5/11/89	59				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Paint Maker	Hemlon Bros	Balto - Md	U.S.A.

13. FATHER'S NAME: George Bayer

14. MOTHER'S MAIDEN NAME: Sabina ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		George Bayer 2006 Belmont Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease — (INTERVAL BETWEEN ONSET AND DEATH) 1 hour
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Wm. H. Kammer, Jr. M.D.		16 Jan. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	1/19/49	Sacred Heart	German Hill Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Lilly & Zeh 403 S. Wolfe St 94a

VS 151

G706.4 ✓ E812.4 N81 3.0 G706.4

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Roy C. Jenkins

2. DATE OF DEATH: 1/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1901 Braddish St. 15-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, ~~WIDOWED~~, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Divorced	Nov. 20, 1911	37		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		TENNESSEE	USA

13. FATHER'S NAME: John Melvin Jenkins

14. MOTHER'S MAIDEN NAME: Jennie C. Magee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
-	-	-

17. INFORMANT: Claude Jenkins ADDRESS: La Junta, Color.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration of vomitus.
atelectasis of lungs.
Fracture of left tibia.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Public	Front of 1811 Boomingdale Rd. 15/6

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
1 17 49 2p.m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Pedestrian struck by taxi cab

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
George G. Merrill M.D.		1/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
REMOVAL	1-18-49	-	La Junta, Colorado

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Wm J. Tickner & Sons	Balto. Md.

VS 151

170c

G70675 ✓ 331 G70675

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): NETTIE MAE SHIPLEY

2. DATE OF DEATH: Jan. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3130 Gwynns Falls Pkwy.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3130 Gwynns Falls Pkwy. 15-37

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
female	white	widowed	Oct. 1,	about 80 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Balto., Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John H. Jefferies	Mary E,

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Mrs. Dicey M. Griffith	1716 Ashburton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage & paralysis — Interval between onset and death: about 8 days
DUE TO arteriosclerosis — ?
hypertension — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — 20

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ~~Oct~~ May 16, 1947 *to* Jan 16, 1949, *that I last saw the deceased alive on* Jan 15, 1949 *and that death occurred at* ____ m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles S. Siebert, M. D.	2220 Garrison Blvd	Jan. 18 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/19/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

83a

G70676 ✓ 196

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70676

1. NAME OF DECEASED (Type or Print): AMELIA KEPPER

2. DATE OF DEATH: Jan. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3310 Shelburne Rd.
c. Length of stay in Baltimore: Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3310 Shelburne Rd. 27 20

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: April 27, 1869
9. AGE (In years last birthday): 79 yrs. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto., Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Philip Fessman
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Fred W. Hockwarth ADDRESS: 3310 ShelburneRd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Primary carcinoma of Bone — INTERVAL BETWEEN ONSET AND DEATH: 4½ yrs.

DUE TO

(B) - Generalized Anteus - Seleus — 5 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. , 1944 *to* Jan. 16, 1949, *that I last saw the deceased alive on* Jan. 16, 1949, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Earl L. Chambers M. D.
23B. ADDRESS: 4108 Liberty Hts. Ave.
23C. DATE SIGNED: 1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/49
24C. NAME OF CEMETERY OR CREMATORY: DRUID RIDGE
24D. LOCATION (City, town, or county) (State): PIKESVILLE - MD.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

55B

G706.7 ✓ 331 G706.7

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE A. SMALLWOOD

2. DATE OF DEATH: Jan.16,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 309 Robert St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 309 Robert St. 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Jan.6,1889	60	0	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant Seaman	Mariner	Baltimore, Md.	

13. FATHER'S NAME: Alias S. Smallwood

14. MOTHER'S MAIDEN NAME: Margaret Bowen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No — Peace time Sailor	216-10-1141	Mrs M. M.Smallwood,309 Robert St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1/16/49 (3hrs)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Second stroke

DUE TO

(C) Cerebral Hemorrhage 1st stroke — 1946

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 26, 1948 *to* Jany 16, 1949 *that I last saw the deceased alive on* Jany 16, 1949, *and that death occurred at* 4.30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. W. Kerr M.D.	1938 Linden Ave	1/18/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/20/49	National	Baltimore, Md..

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 18 1949	Tunstington for Williams, M.D.	William Cook, Inc.,1217 St.Paul St.

VS 150

83a

G70678

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 70.2 - N971

Registered No. G70678

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JESSIE D. M. ONKST

2. DATE OF DEATH: January 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2907 N. Charles Street 12-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married	1890	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Huntington, Pennsylvania	

13. FATHER'S NAME: Frank Fetterhoff

14. MOTHER'S MAIDEN NAME: Lyle Milburn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		James Mullaney	7419 Kenley Avenue

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Barbiturate Poisoning	
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Garage	Rear of 2328 St. Paul Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21F. HOW DID INJURY OCCUR?
January 11, 1949 p m.		Ingestion of sleeping tablets

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
M.D.		1-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1/19/49	Methodist	Huntingdon, Pennsylvania

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington, Pennsylvania, M.D.	Wm. Cook, Inc.,	1217 St. Paul Street

VS 151

163B

BALTIMORE CITY HEALTH DEPARTMENT 491 ✓ G706.79 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 ST. PAUL STREET.
(c) Hospital or institution: 11.01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 ST. PAUL ST. (If rural give location)
(e) Citizen of foreign country? N/A. (Yes or No) If yes, name country

3 (a) FULL NAME JAY H. TREXLER ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of ~~husband~~ or wife: ELIZABETH J. TREXLER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): MAY 11, 1887

8. AGE: Years: 61 | Months: 8 | Days: 7 | If less than one day: hr. min.

9. Birthplace: MERZTOWN, PENN.
(Town, county, and state)

10. Usual Occupation: ENGINEER: LUBRICATION
11. Industry or business: SHELL OIL CO.

FATHER
12. Name: JAMES J. TREXLER
13. Birthplace: PENNSYLVANIA.

MOTHER
14. Maiden Name: EMMA DIENER
15. Birthplace: PENNSYLVANIA.

16 (a) Informant: ELIZABETH J. TREXLER
(b) Address: 1001 ST. PAUL ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 18, 1949 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mertztown, Location Mertzthon, Pa

18 (a) Funeral director: Wm. J. Fichner + Sons
(b) Address: North & Pa. Ave. - Balto. 17, Md.

19 (a) 19 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 18 1949 at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 14 1949 to JAN 18 1949, and that I last saw him alive on JAN. 17 1949.

	Duration
Immediate cause of death: BRONCHO-PNEUMONIA.	1 WEEK
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Wilbur Karl Jr. M. D.
Address: 4230 HOCH RAVEN Date signed: 1-18-49

VS 150

107

G70680 ES-126071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H42 G70680 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Esther Smith

2. DATE OF DEATH Jan. 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTO. CITY HOSPITALS

c. Length of stay in Baltimore 18 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.

D. STREET ADDRESS (If rural, give location) 247 S. Durham Street.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married (Sep)	? 1908?	40?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		N.C.	

13. FATHER'S NAME Israel Whitus

14. MOTHER'S MAIDEN NAME Henrietta ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		RECORDS-BALTO. CITY HOSPITALS	4940 EASTERN AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremic pericarditis — DUE TO — (INTERVAL BETWEEN ONSET AND DEATH) ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ~~Uremia~~ Hypertensive cardio-renal disease — DUE TO — ?

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Infected scabies

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-14, 1949, *to* 1-15, 1949, *that I last saw the deceased alive on* 1-15, 1949, *and that death occurred at* 9:00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David H Marvin M. D.	4940 Eastern Ave.	1-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	1-21-49	Spring Branch Cem.	Greenville N. C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 19 1949	Huntington Williams, M.D.	Elroy O. Wilson	1000 Brantley Ave

VS 150

131a

G70681 ✓ 420.1 G70681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH REED COALE

2. DATE OF DEATH 1-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Harford Bel Air
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bel Air
D. STREET ADDRESS (If rural, give location) 44 Broadway

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	W. Widower	1-12-1874	74	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Real Estate		Baltimore, Md.	USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME Mary Elizabeth McFadden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (Patient's chart) ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Myocardial Infarction	7 days
DUE TO		
(B)	~~Hypo~~ Coronary Occlusion	
DUE TO		
(C)	Arteriosclerosis and Hypertension (Defer Dis)	years
	Hypostatic pneumonia, bilateral	2 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Jan. 16, 1949, *to* Jan. 18, 1949, *that I last saw the deceased alive on* Jan. 18, 1949, *and that death occurred at* 7:25 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. T. Coale 3d M. D.	Union Memorial Hospital	1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jany 21	Friendship	Near Bel Air Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 19 1949	Thurlington Williams, M.D.	Joseph T. Foster	Bel Air Md

VS 150

Foster 93

0682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ X 427.1 670682 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3960 Brooklyn Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County York
(c) City or town New Freedom (If outside city or town limits, write RURAL and give town)
(d) Street No. Main St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Elizabeth Rosier.-

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow.

6 (b) Name of husband or wife Benson Rosier
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 7, 1865

8. AGE: Years	Months	Days	If less than one day
83	3	11	hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home,

FATHER
12. Name Feldy Echtol.-
13. Birthplace Unknown.-

MOTHER
14. Maiden Name Unknown.-
15. Birthplace Unknown

16 (a) Informant Mrs. Chas. M. Warner
(b) Address New Freedom, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21, 1949 (month) (day) (year)
(c) Cemetery or crematory New Market Cem.
Location Maryland Line, Md.

18 (a) Funeral director Jacob Harlenstein
(b) Address New Freedom, Pa.

19 JAN 19 1949 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 1949, at 5:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1948 to Jan 18 1949
and that I last saw her alive on Jan 18 1949

Immediate cause of death Myocardial insufficiency

Due to —

Due to —

Other Conditions Arteriosclerosis Myocarditis.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature John C. Schenck
Address 1337 S. Charles St. Date signed 1/18/49 M. D.

VS 180

93

G70683 ✓ X

BALTIMORE CITY HEALTH DEPARTMENT 193 G70683

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Howard Reed

2. DATE OF DEATH: 1-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. 11 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa. B. COUNTY: Schuylkill
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Manchester
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	married	Jan 29 1881	67	11	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lewistown Pa.
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Charles Reed
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Reed ADDRESS: Manchester, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral edema
DUE TO
(B) Glioma, temporal, left
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-15-49	Glioma - left temporal	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-8, 1949, to 1-18, 1949, *that I last saw the deceased alive on* 1-18, 1949, *and that death occurred at* 7:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred R. McCrumb, Jr. M. D.	University Hosp.	1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1/18/48	Mt. Laurel	Pottsville, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 19 1949	Huntington Williams, M.D.	Claude A. Lord	Pottsville Pa.

VS 150.

54a

G70684 BALTIMORE CITY HEALTH DEPARTMENT 420.0 G70684

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH OMINSKY

2. DATE OF DEATH: January 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2005 Eagle Street 20-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Leather Goods Cutter
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ike Morris Ominsky
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-07-9816
17. INFORMANT: Samuel Ominsky ADDRESS: 3920 Boarman Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) A.S.E.J.P.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: January 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 19/49
24C. NAME OF CEMETERY OR CREMATORY: Workmen Circle Cemetery
24D. LOCATION (City, town, or county) (State): German Hill Road

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS: 1126 W North ave

VS 151 - [illegible] 93D

G70685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 G70685 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 W. Lafayette Ave.
(c) Hospital or institution: 17-or

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aria Parks

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife Daniel Parks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1892

8. AGE: Years	Months	Days	If less than one day
56	3	10	hr. min.

9. Birthplace Sumter, South Carolina (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Samuel Holmes
13. Birthplace S. C.

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Daniel Parks
(b) Address 1368 Woodyear Dr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19, 1949 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Baltimore, Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pennsylvania Ave.

JAN 19 1949 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1949, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1949 to 1/16 1949.
and that I last saw h[illegible] alive on 1/14 1949.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Hypertension	
Due to Cardio Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rev. H. Williams
Address 46 N. Gilmor St. Date signed 1/17/49

VS 150

937

0686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

174

Registered No. 6-0686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 N. Stricker St.
(c) Hospital or institution: 16-0
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 1
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Henry Cole

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1888

8. AGE: Years 60 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace A. A.; County, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Way Green
13. Birthplace A. A.; County, Md.

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Henry Cole
(b) Address 1010 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19, 1949 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Baltimore, Md.

18 (a) Funeral director Geo. W. Gibson
(b) Address 1008 Pennsylvania Ave.

19. JAN 19 1949 (Date received by registrar) (Signature of registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1949, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1948 to Jan 17 1949, and that I last saw [illegible] alive on Jan 17 1949.

Immediate cause of death Carcinoma of Uterus — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. McWilliams M.D.

Address 414 N. Johnson Date signed 1-19-49

VS 180

48C

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70687 ✓ 420.1 G70687

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Andrew Philip Eck

2. DATE OF DEATH: January 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR ~~XXXXXXXXX~~ (If not in hospital or institution, give street address or location): St. Joseph's
c. Length of stay in Baltimore: 47 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1508 Lockwood Rd. 27-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M.	W.	Married	January 29, 1888	60 yr.	11	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Purchasing Agent	Mutual Chemical Co.	Maryland	

13. FATHER'S NAME: Charlee H. Eck

14. MOTHER'S MAIDEN NAME: Sallie Base

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs. Edna A. Eck	1508 Lockwood A.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis

DUE TO

(B) Arterio-sclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 31, 1948 *to* Jan. 17, 1949, *that I last saw the deceased alive on* Jan. 17, 1949, *and that death occurred at* 1:25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul Peters Jr. M. D.	1400 N. Caroline St.	Jan. 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	1/20/49	Druid Ridge	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 19 1949	Huntington Williams, M.D.	H. H. Mears & Son	805 N. Calvert St

VS 150

939

G70688 ✓ 422.1 G70688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Nora Barrett

2. DATE OF DEATH: January 18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for the Aged Poor
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1200 Valley La. 10-01

5. SEX F
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W.
8. DATE OF BIRTH July 25, 1868
9. AGE (In years last birthday) 80 79
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Cully
14. MOTHER'S MAIDEN NAME Bridget Higgins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Sister Ignatius, Sup. ADDRESS 1200 Valley La.

MEDICAL CERTIFICATION

18. CAUSE OF ~~DEATH~~

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio Sclerosis — 10 yrs

DUE TO

(C) Chronic Diarrhoea — 1 week

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1949 *to* Jan 18, 1949, *that I last saw the deceased alive on* Jan 17 1949, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23A. SIGNATURE E. Gill Hall M.D.
23B. ADDRESS 1631 E. North Ave
23C. DATE SIGNED Jan 18-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/21/49
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge
24D. LOCATION (City, town or county) (State) Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR H. N. Mears Son ADDRESS 808 N. Calvert St 93

VS 150.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 689

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3727 Edmondson Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) more than 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3727 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie V. Breyer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Widow

6 (b) Name of husband or wife Frank Frank Breyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9, 1871

8. AGE: Years	Months	Days	If less than one day
78	3	11	hr. min.

9. Birthplace Washington D. C.
(Town, county, and state)
10. Usual Occupation House wife.
11. Industry or business —

FATHER
12. Name JOHN SHEPPACH
13. Birthplace ?

MOTHER
14. Maiden Name CAROLINE ELNICK
15. Birthplace ?

16 (a) Informant MISS MINNIE BREYER
(b) Address 6012 BORGER AVE

17 (a) BURIAL (b) Date thereof 1/21/49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location BALTO. MD.

18 (a) Funeral director JOHN. T. STANBURY
(b) Address 2700 EDMONDSON AVE.

19 (a) JAN 19 1949 (b) Huntington for Williams & P
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1949, at 5:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1940 to Jan. 18 1949, and that I last saw her alive on Jan. 17 1949.

Immediate cause of death: Coronary occlusion — Duration: 1 day

Due to: Hypertension — 10 yrs.

Due to: Age, arteriosclerosis

Other Conditions: Fatty degeneration of myocardium. (myocarditis)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Parker M. Baggett M. D.
Address 3812 Greenmount Ave. Date signed Jan 19 '49

VS 150

937

G70690

BALTIMORE CITY HEALTH DEPARTMENT 4 20 1 G70690

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Amelia V. Muller

2. DATE OF DEATH: January 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2211 N. Charles St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

C. Length of stay in Baltimore: 72 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 N. Charles St. 1-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Oct. 11, 1876	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Baltimore, Md.	U.S.

13. FATHER'S NAME: William Thode

14. MOTHER'S MAIDEN NAME: Amelia VanBokhelin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mrs. Amelia P. Stirling	2211 N. Charles S

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Thrombosis	12 hrs.
DUE TO (B)	Generalized Arteriosclerosis	10 yrs.
DUE TO (C)	Paralytic Stroke	5 yrs.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* Jan 16, 1949, *that I last saw the deceased alive on* 1-16, 1949 *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thom E. Nelson M. D.	3 W. Biddle St., Baltimore	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/19/49	Druid Ridge	Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 19 1949	Huntington Williams, M.D.	John O. Mitchell & Sons, Inc.-1900 Eutaw Pl

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S.70691 ✓

670691

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 670691 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Holmes

2. DATE OF DEATH 1-18-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1710 Calhoun

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 1710 Calhoun
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md
D. STREET ADDRESS (If rural, give location) 1710 Calhoun 5-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months, Days	If Under 24 Hours Hours, Min.
M	Negro	Married	March 10/1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Labor		

13. FATHER'S NAME Henry Matthews

14. MOTHER'S MAIDEN NAME Lue Eldridge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO

17. INFORMANT Louise Chambers ADDRESS 1710 Calhoun

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Hypertension

DUE TO

(C) Arterio Sclerosis

INTERVAL BETWEEN ONSET AND DEATH
(A) Ida

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-17-, 1949 *to* 1-17-, 1949 *that I last saw the deceased alive on* 1-17-, 1949, *and that death occurred at* 7:10 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[illegible] M. D.	1133 [illegible]	1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 20/49	Scottsville Va	Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 19 1949	Huntington Williams, M.D.	Va Brooks	1463 N. Carey St

VS 150

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70692 70692 ✓ G70692

BALTIMORE CITY HEALTH DEPARTMENT 422.1 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 Gold St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Gold St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1870

8. AGE: Years	Months	Days	If less than one day hr.	min.
78	8	25		

9. Birthplace Calvert Co. Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William Wilson
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Margaret Ray
15. Birthplace Calvert Co. Md

16 (a) Informant Irene King
(b) Address 615 Gold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20/49 (month) (day) (year)
(c) Cemetery or crematory Druid Hill Mt Auburn
Location West Port

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 JAN 19 1949 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1949 at 12 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1946 to Jan 17 1949 and that I last saw her alive on Jan 17 1949.

Immediate cause of death Cardio Vascular Disease — Duration 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Irey
Address 1928 Penna Ave Date signed 1/18/49

VS 150

937

0693 Pal 6 ✓ 163 G70693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Otto Lalli (OTTO WM. LALLI) — 2. DATE OF DEATH: JAN 16 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 27 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5008 Foster Ave 4605

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	4-29-99	49				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Beth. Steel Co.	Finland	U.S.A.

13. FATHER'S NAME: Mike Lalli
14. MOTHER'S MAIDEN NAME: MARY PRYKA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-09-2536
17 INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchogenic carcinoma	1 yr
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-13- 1949 *to* 1-16- 1949, *that I last saw the deceased alive on* 1-16- 1949, *and that death occurred at* 4:40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William W. Winternitz M. D.	JOHNS HOPKINS HOSPITAL	1-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1/20/49	Oak Lawn Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR — ADDRESS
JAN 19 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC. BALTIMORE, MARYLAND

VS 150 — 47c

G70694

BALTIMORE CITY HEALTH DEPARTMENT 332 G70694

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARY JULIA VanTRUMP

2. DATE OF DEATH: Jan. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hilton Nursing Home 3520 Hilton Street

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3520 Hilton St. 15-11

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Feb. 27, 1869
9. AGE (In years last birthday): 79 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? Miller
14. MOTHER'S MAIDEN NAME: Mary Overbeck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Miss A. Catherine Overbeck ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Softening — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
DUE TO
(B) Arteriosclerosis, general — 10 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Senility. — 10 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypertension — 30 yrs.

19A. DATE OF OPERATION: 1933, 1939
19B. MAJOR FINDINGS OF OPERATION: Cystic Tumor - benign. Toxic thyroid adenoma.
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): none
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): none
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): none
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? none

22. *I hereby certify that I attended the deceased from* July 22, 1936, *to* January 17, 1949, *that I last saw the deceased alive on* January 13, 1949, *and that death occurred at* 4 20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. J. Chalfant M.D.
23B. ADDRESS: 6710 York Road
23C. DATE SIGNED: Jan. 18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC. ADDRESS: BALTIMORE, MARYLAND

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670695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

175

Registered No. 670695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 Ridgley Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Ridgley Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Elizabeth Herring

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: William Herring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 22, 1893

8. AGE: Years 55 | Months 8 | Days 27 | If less than one day: hr. min.

9. Birthplace: Hyed County North Carolina (Town, county, and state)

10. Usual Occupation: Hair Dresser

11. Industry or business

FATHER
12. Name: Moses Watson
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: William Herring
(b) Address: 1009 Ridgley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 23, 1949 (month) (day) (year)
(c) Cemetery or crematory: New Bern, North Carolina
Location: Craven County

18 (a) Funeral director: Joseph A. Lively
(b) Address: 66 West Baltimore Street

19 JAN 19 1949 (Date rec'd by registrar) (Registrar) William [illegible], M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 19 1949, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Jan 19 1949 and that I last saw h[illegible] alive on 1/18 1949.

Immediate cause of death: Respiratory failure

Due to: Carcinoma ovary.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: L. Shorofsky M.D.
Address: 601 N. Monroe St. Date signed: 1/19/49

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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G70696 180 G70696

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LIA ZEMEL
2. DATE OF DEATH: 1-19-49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 518 Rubin Ave
C. Length of stay in Baltimore: 26 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27
D. STREET ADDRESS (If rural, give location): 518 Rubin Ave 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widow		69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Russia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harry Gerson	Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Max Zemel	6043 Park Heights Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Malignancy of Lungs — DUE TO — (INTERVAL BETWEEN ONSET AND DEATH) about 14 months

(B) Hypernephroma (HYPERNEPHROMA) Rt Kidney — DUE TO — about 5 yrs

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July-1944	Hypernephroma	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July-1944 19__, to Jan-19-1949 *that I last saw the deceased alive on* Jan-19-1949 *and that death occurred at* 8:15 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr. Herman Seidel M. D.	2404 Eutaw Pl	1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	1-19-49	Hebrew Hooring Mem	Balto	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 19 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

52a

G70697

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70697

1. NAME OF DECEASED (Type or Print): Neil A. Ross (Neil A. Ross)
2. DATE OF DEATH: 18 Jan. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
DOA
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY: Leigh
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Allentown
D. STREET ADDRESS (If rural, give location): 1221 Union Blvd.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 30, 1888
9. AGE (In years last birthday): 60 yrs. (If under Months / Days / Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Jessup, Iowa
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph E. Ross
14. MOTHER'S MAIDEN NAME: Bessie Seigfried
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: Mrs. C. S. Diefenderfer-2132 South Land Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 18 Jan. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/19/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Allentown, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WILLIAM J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 151

94a

G70698 CERTIFICATE CORRECTED 2-7-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT 443 G70698

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CORA MAY JONES

2. DATE OF DEATH: Jan. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2713 Orleans St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2713 Orleans St. 6-0 r

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct. 18, (1871) (1870)
9. AGE (In years last birthday): (78) 77
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Edward D. Jones
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-12-6676
17. INFORMANT: Dorothy Fink, ADDRESS: 2713 Orleans St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Tuberculosis — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

over

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): No
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): No.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: No m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: No.

22. *I hereby certify that I attended the deceased from* 1-10, 1949, *to* 1-18, 1949, *that I last saw the deceased alive on* 1-17, 1949, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis Vogel Jr M. D.
23B. ADDRESS: 26 E. Monument St.
23C. DATE SIGNED: 1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: 1/19/49
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 15a

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G70699

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 443

G70699

Registered No.

1. NAME OF DECEASED (Type or Print): Herman C. Gubisch

2. DATE OF DEATH: 1-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: 12 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Frederick
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Frederick
D. STREET ADDRESS (If rural, give location): 700 E Patrick Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married		56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookkeeper	mercantile	Maryland	USA

13. FATHER'S NAME: Carl Gubisch

14. MOTHER'S MAIDEN NAME: Emma Kuhler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown	214-10-1391	Mrs. H. C. Gubisch (wife)	Same as deceased

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cerebro-vascular accident (central hemorrhage) — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

(B) Hypertensive Cardio-vascular disease — 10 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-6-, 1949 *to* 1-18-, 1949 *that I last saw the deceased alive on* 1-18-, 1949 *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Hays Rosser M. D.	University Hospital	1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-21-49	Mt. Olivet	Frederick, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR ADDRESS
JAN 19 1949	Huntington Williams M.D.	M.R. Etchison & Son Frederick, Md.

VS 150

937

G70700 ✓ H22.1 443 G70700

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) MARY-E. WEISHAAR. 2. DATE OF DEATH Jan. 17-1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 203-S. Loudon Ave.

c. Length of stay in Baltimore 70yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.

D. STREET ADDRESS (If rural, give location) 203-S. Loudon Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed.	March-19-1861.	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse. (Retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Carroll Co: Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frederick Darkis.

14. MOTHER'S MAIDEN NAME Mary Ekas.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.

16. SOCIAL SECURITY NO None

17. INFORMANT Mrs. Joseph Beehler. ADDRESS 203 S. Loudon Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension — months

DUE TO

(C) Arterio-Sclerosis. Senilitis

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. I hereby certify that I attended the deceased from June, 19 44 to Jan 17, 19 49, that I last saw the deceased alive on 1/17/49, 19 ___, and that death occurred at 8.45 P. m., from the causes and on the date stated above.

23A. SIGNATURE Helen S Sasser M. D.

23B. ADDRESS 4 Edmondson

23C. DATE SIGNED 1/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial.

24B. DATE Jan. 20-49.

24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, - Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 19 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Charles J. Schwab. 3512 Fred'k. Ave.

VS 150

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G70701 Urology 2246

BALTIMORE CITY HEALTH DEPARTMENT 200-1 G70701

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Bernard Rosenfeld
2. DATE OF DEATH: Jan. 18, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland; Hosp. Marburg 3
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore; D. STREET ADDRESS (If rural, give location) 517 N. Collington Ave
3B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
3C. Length of stay in Baltimore: 47 years (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	8-5-01	47 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance Agent
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Israel Rosenfeld
14. MOTHER'S MAIDEN NAME: Rebecca Poglinsky
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-05-5058
17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Circulatory collapse — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs.

(B) DUE TO: Lymphosarcoma

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-15-, 1949, *to* 1-18-, 1949, *that I last saw the deceased alive on* 1-18-, 1949, *and that death occurred at* 2:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE, M.D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 20, 1949
24C. NAME OF CEMETERY OR CREMATORY: Sharrei Tfiloh Cem
24D. LOCATION (City, town, or county) (State): Windsor Mill Road Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1124 W NORTH Ave

VS 150

55E

G70702 ✓ X G70702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 456 Registered No.

1. NAME OF DECEASED (Type or Print): Victoria Wright

2. DATE OF DEATH: Jan. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 735 Arondale Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Married	Nov. 10, 1908	30	2 / 9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William David

14. MOTHER'S MAIDEN NAME: Hattie Watts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: George F. Wright ADDRESS: 735 Arondale Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Endocarditis — 1 month

DUE TO

(C) Lupus erythematosus disseminatus — 3-4 months

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 4, 1949, *to* Jan 18, 1949, *that I last saw the deceased alive on* Jan 18, 1949, *and that death occurred at* 6:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert C. Hunter M.D.

23B. ADDRESS: Univ. Hospital

23C. DATE SIGNED: 1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 21 1949

24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Pk.

24D. LOCATION (City, town, or county) (State): Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: 1-19

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. George H. Holland ADDRESS: 1631 Druid Hill Ave.

VS 150

91c

G70703

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.0 G70703

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): JOHN F. SOMMERLOCK
2. DATE OF DEATH: Jan. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 416 N. Hilton St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 416 N. Hilton St. 2017

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Widow	April 30, 1865	83 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		Baltimore, Md.	

13. FATHER'S NAME: John F. Sommerlock
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Mrs. Mabel B. Miles	2518 Harlem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic C-V Disease	20 years
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 25, 1947 *to* January, 1949 *that I last saw the deceased alive on* Jan 10, 1949, *and that death occurred at* 9.20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Morris W. Steinberg M. D.	410 N. Hilton St	Jan 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/20/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 19 1949 JAN 20 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

93D

G70704 ✓ 422.1 G70704

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MARY IMOGENE NICHOLS

2. DATE OF DEATH: Jan. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for the Aged of the Methodist Church - 2211 W. Rogers Ave.
c. Length of stay in Baltimore: 89 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 W. Rogers Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Jan. 17, 1860
9. AGE (In years last birthday): 89 yrs. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Frank McLaughlin
14. MOTHER'S MAIDEN NAME: Sarah Hood
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Miss Miriam O. Coates - ADDRESS: 2211 W. Rogers Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Myocardial Insufficiency	1 day
DUE TO (B)	Arteriosclerosis	10 yrs.
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct - 12, 1941, *to* Jan 16, 1949, *that I last saw the deceased alive on* Jan 16, 1949, *and that death occurred at* 9 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Arthur J. Bauer M. D.
23B. ADDRESS: 800 W. 33rd St
23C. DATE SIGNED: 1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

93D

G70705 BALTIMORE CITY HEALTH DEPARTMENT 163 G70705

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RUSSELL D. NILLER

2. DATE OF DEATH: Jan. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1847 E. 30th St.

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1847 E. 30th St. 9 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
male	white	married	April 10, 1893	55 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
President	Md. Hotel Supply Co.	Baltimore, Md.	

13. FATHER'S NAME: Daniel J. Niller

14. MOTHER'S MAIDEN NAME: Bertha Seebach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes			Mrs. Corinne D. Niller	1847 E. 30th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Broncho Pneumonia	2 days
DUE TO (B)	Bronchogenic Carcinoma	2 mos
DUE TO (C)	Hypertension arteriosclerosis Bronchectasis	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* June, 1941, *to* Jan 17, 1949, *that I last saw the deceased alive on* Jan 17, 1949 *and that death occurred at* 9:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm Shearer Lord M. D.	20 E. Baston St	1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/20/49	Greenmount Entombment	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN [illegible] 1949	[illegible] Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 130

JAN 28 1949

47c

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70706 ✓ 421.4 G70706

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. G70706 Registered No.

1. NAME OF DECEASED (Type or Print): Jennie M. Winterling
2. DATE OF DEATH: 1/16/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3728 Foster Ave
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3728 Foster Avenue 26-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	Widowed	9/12/74	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife -
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Balto -
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Buettner
14. MOTHER'S MAIDEN NAME: Clara ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Frederick Winterling ADDRESS: 3728 Foster Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: before 1939

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Coronary Occlusion — 1 yr

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertrophied Heart

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 15, 1939 *to* Jan. 16, 1949, *that I last saw the deceased alive on* Jan. 15, 1949, *and that death occurred at* 2:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lucien Tooke M. D.	845 N. Patterson Park Ave	1/18/49

24A. BURIAL, CREMATION, REMOVAL, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	1/20/49	Sacred Heart	German Hill Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Lilly & Zeiler	403 S. Wolfe St

93D

Correct age is especially important. Physicians: please write the cause of death clearly and [illegible]

G70707 BALTIMORE CITY HEALTH DEPARTMENT 420.0 G70707

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Clara V. Snyder
2. DATE OF DEATH: 1/17/1949
3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. Md.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland; B. COUNTY:
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 206 E. Fort Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 206 E. Fort Ave. 1-4-C3
c. Length of stay in Baltimore (Yrs. Mos. Days): Life
6. SEX: Female
7. COLOR OR RACE: White
8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
9. DATE OF BIRTH: Aug. 7-1860
10. AGE (In years last birthday): 88 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto. Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: GEORGE WEAVER
14. MOTHER'S MAIDEN NAME: UNKNOWN.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Joseph G. Snyder Sr. ADDRESS: 206 E. Fort Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/13, 1949, *to* Jan. 17, 1949, *that I last saw the deceased alive on* Jan. 17, 1949, *and that death occurred at* 11:40 *a. m., from the causes and on the date stated above.*

23A. SIGNATURE: H. P. Friedman, M. D.
23B. ADDRESS: 1319 Light St.
23C. DATE SIGNED: 1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-21-1949
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Flynn & Fleming ADDRESS: 1426 Light St.

937

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

BIRTH NO. G70708

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 G70708 Registered No.

1. NAME OF DECEASED (Type or Print): Samuel J. White Sr.

2. DATE OF DEATH: January 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1131 Haubert Street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1131 Haubert Street 24-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	Months	Days	If under 24 hours: Hours	Min.
Male	White	Widowed	Feb. 26, 1868	80	10	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	B&O. R.R.	Baltimore, Md	

13. FATHER'S NAME: Barney B. White

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Samuel J. White Jr. ADDRESS: 806 Mt. Holly St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1/2/49 - 1/17/49

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis — 2

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Senility — 2.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec, 1948, *to* Jan 17, 1949, *that I last saw the deceased alive on* Jan 16, 1949, *and that death occurred at* 12:05 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter Kohn M. D.	102 E. Fort Ave	1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/20/1949	Holy Cross	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Flynn & Fleming	1426 Light St.

83a

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Catherine C. Beyer

2. DATE OF DEATH Jan 17-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 443 S. Augusta Ave

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 443 S. Augusta Ave 20-0.8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	June 7-1886	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Presser	Garment	Baltimore Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Daniel Murphy	Mary Dee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or No, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	217-10-5366	Mary C. Chetelat 443 S. Augusta Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Arterial Hypertension — 8 yrs

DUE TO

(C) Cardio Renal Disease ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1/15, 1949 *to* 1/17, 1949, *that I last saw the deceased alive on* 1/17, 1949, *and that death occurred at* 5:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. B. Hesselbacher M. D.	4209 Hudnick Ave	1/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 21-1949	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
[illegible] 19 [illegible]	Huntington Williams, M.D.	Roth & B. M. Walters	1901 E. Fayette St

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ES-12587 67071 BALTIMORE CITY HEALTH DEPARTMENT 67071

CERTIFICATE OF DEATH 193

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mary Jane Proctor

2. DATE OF DEATH: Jan. 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Crownsville, Md. (Oxenhill, Md.)
D. STREET ADDRESS (If rural, give location): Crownsville, Md 6121 St. Rehabas Rd. Oxenhill, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	May 30, 1917	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: RECORDS BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brain Tumor. — INTERVAL BETWEEN ONSET AND DEATH: C 3 mo

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

over

19A. DATE OF OPERATION: 1-18-49

19B. MAJOR FINDINGS OF OPERATION: Intermed Hydrocephalus due to Ventr. Tumor

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-7 *, 19*49*, to* 1-19 *, 19*49*, that I last saw the deceased alive on* 1-19 *, 19*49*, and that death occurred at* 5:45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Louis A. J. Monsaville M. D.

23B. ADDRESS: Balto City Hosp

23C. DATE SIGNED: 1-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-22-49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State): Oxen Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Mrs Frances A. Hemsley ADDRESS: 578 W. W. Biddle St

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) William Hammond — 2. DATE OF DEATH Jan. 16 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1726 Barnes St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) I726 Barnes St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Col.	Single	Dec. 14 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	U.S.A.

13. FATHER'S NAME: George Hammond

14. MOTHER'S MAIDEN NAME: Annie Washinton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Martha Henson	I726 Barnes

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Myocarditis — ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑
—		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/10, 1949, *to* 1/16, 1949, *that I last saw the deceased alive on* 1/16, 1949 *and that death occurred at* 11:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leland L. Lafferd M. D.	622 N. Bond St	1/19/49

24A. BURIAL, CREMATION (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 20 1949	Mt. Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 18 1949	Huntington Williams, M.D.	Elroy O. Wilson	1000 Brantly Ave.

93E

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70712 ✓ ✗ G70712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 142.1

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 58 days
(e) Length of stay in Baltimore (yrs., mos., or days): 58 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Ark. (b) County:
(c) City or town: Blythesville (If outside city or town limits, write RURAL and give town)
(d) Street No.: 916 Clark St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: JACK MATTHEW FERGISON

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: 431-18-6140

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nora ?

6 (c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Nov. 29, 1884

8. AGE: Years: 64 | Months: 1 | Days: 20 | If less than one day: hr. min.

9. Birthplace: S.D. (Town, county, and state)

10. Usual Occupation: Bredgeman

11. Industry or business: Seafarer

FATHER
12. Name: Geo. Fergison
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Donna Mc Caffrey
15. Birthplace: NJ

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 24-49 (month) (day) (year)
(c) Cemetery or crematory: Blythville
Location: Blythville Arkansas

18 (a) Funeral director: C Bennett Arrgood
(b) Address: 3911 Liberty Heights

19 (a) 1-19 1949 (b) [illegible] registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 18 1949, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1948, to Jan. 18 1949, and that I last saw him alive on Jan. 18 1949.

	Duration
Immediate cause of death: 1- Adenocarcinoma left parotid with local metastasis	Unknown
Due to: 2- Necrosis of primary tumor	Unknown
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 1/18/49

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E812.9 G70713
H829.0

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward T. Walsh

2. DATE OF DEATH: 1/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General
C. Length of stay in Baltimore: Yrs. 6 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2615 Lehman St. 20-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 1 Hour: Hours	Min.
M	W		Dec. 18, 1897	51	0	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Poultrymen		Balto.	USA

13. FATHER'S NAME: Thomas J. Walsh

14. MOTHER'S MAIDEN NAME: Catherine Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Charlotte Saunders ADDRESS: 816 Primson Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Multiple fractures
(B) Shock

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: other conditions -- acute alcoholism

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Near Washington 20-08 4000 block of Frederick Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 17 49 6P M.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by truck

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): JAN. 20'49
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: ST PETERS
24D. LOCATION (City, town, or county) (State): BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry A Wiltse ADDRESS: 1702

VS 151

Dr. Fisher G-0714 ✓ 420.2
1823 B. Washington

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G-0714

1. NAME OF DECEASED (Type or Print): ELIZABETH MAISCH BORMUTH

2. DATE OF DEATH: JAN. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 Paddington Court
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2 Paddington Court 27-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
female	white	widowed	Oct. 28, 1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Maryland	

13. FATHER'S NAME: Martin Maisch

14. MOTHER'S MAIDEN NAME: Catherine Bischoff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs. C. Helldorfer	2 PaddingtonCt.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Angina Pectoris — 5 yrs.

DUE TO

(C) Anemia

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 21, 1948, *to* Jan 17, 1949, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leon Fisher M. D.	1823 B. Wash. Blvd.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-20-49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 19 1949	Huntington Williams, M.D.	Leonard J. Ruck	5305 Harford Road.

VS 150

93E

G70715

BALTIMORE CITY HEALTH DEPARTMENT ✓ 164 B. Registered No. G70715

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pier #6--Pratt Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State U (b) County
(c) City or town N (If outside city or town limits, write RURAL and give town)
(d) Street No. K (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY BOUGHAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 45 (?) | Months | Days | If less than one day hr. min.

9. Birthplace UNKNOWN (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name U
13. Birthplace N

MOTHER
14. Maiden Name K
15. Birthplace N

16 (a) Informant O
(b) Address W

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School JAN 5 1949
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 JAN 19 1949 (Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1948, at 12:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-19-48 at 10:25 P.M.
(b) Where did injury occur? Pier #6--Pratt Street
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? No
(d) Means of injury Jumped overboard

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed 12/20/48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C-0716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
University Hospital 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STEVE O'DONALD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years: 63 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state) Unknown

10. Usual Occupation Storekeeper

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant:
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Johns Hopkins Medical School JAN 13 1949
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 (b) JAN 19 1949 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1948, at 4:10 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12/29/48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07317

BALTIMORE CITY HEALTH DEPARTMENT ✓ 94a Registered No. 07317

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Johns Hopkins Hospital
(c) Hospital or institution:
3-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 E. Gough Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN ULRICH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace U N (Town, county, and state)

10. Usual Occupation X

11. Industry or business N

FATHER 12. Name O

13. Birthplace N

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant NONE

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School JAN 4 1949

Location

18 (a) Funeral director Commissioner of Health

(b) Address

19 JAN 19 1949 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1948, at 2:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.

Date signed 12/24/48

VS 151

Please write plainly, with pen and ink, and make no erasures. Answer questions fully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB 135713 G70718 ✓ 420.0 G70718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Walter Watson

2. DATE OF DEATH Jan. 2-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 50 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 604 W. Redwood Street 4-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	WHITE	Single	May 16- 1887	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) District of Columbia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unk (D)

14. MOTHER'S MAIDEN NAME Unk (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Baltimore City Hospitals records- ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROTIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION NONE

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) NONE

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-1-, 1949, *to* 1-2, 1949, *that I last saw the deceased alive on* 1-2, 1949, *and that death occurred at* 6:00A *m., from the causes and on the date stated above.*

23A. SIGNATURE Thomas P. Jeffreys M. D.

23B. ADDRESS BALTIMORE CITY HOSPITALS

23C. DATE SIGNED 1-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY Johns Hopkins Medical School

24D. LOCATION (City, town, or county) (State) JAN 13 1949

DATE RECEIVED BY LOCAL REGISTRAR JAN 19 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS

Commissioner of Health

VS 150

93D-

✓ 161

BIRTH NO. G70719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70719

1. NAME OF DECEASED (Type or Print): George Aouterback

2. DATE OF DEATH: 1-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-2
D. STREET ADDRESS (If rural, give location): 842 E Pratt St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	S	6-1-81	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore Md	U.S.A.

13. FATHER'S NAME: John Aouterback

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-14-2885

17. INFORMANT: Self ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Larynx — INTERVAL BETWEEN ONSET AND DEATH: 18 mos.
DUE TO Recurrent
(B) Malnutrition
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-7-48	Carcinoma of Larynx	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-26-, 1948 *to* 1-16-, 1949, *that I last saw the deceased alive on* 1-16-, 1949, *and that death occurred at* 3:15 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allyn F. Judd M. D.	Mercy Hospital	1-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/20/49	Sacred Heart	Fernow Hill Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 20 1949	[illegible]	J. J. Foley & Sons	1218 Light St

47a

Exact age is especially important. Physician: please write the cause of death clearly and legibly.

G70720 ✓ 443 420.1 G70720

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MINNIE E. AMBROSE

2. DATE OF DEATH: Jan. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2108 Boyd Street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2108 Boyd Street 20-4

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Nov. 30, 1872
9. AGE (In years last birthday): 76 — If under 1 Year: Months 1, Days 18 — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Frederick Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Otha W. Harris
14. MOTHER'S MAIDEN NAME: Mary Jane Keeney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT — ADDRESS: Mrs Frances Kelly, 2108 Boyd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure
DUE TO
(B) Hypertensive-Arteriosclerotic
DUE TO Cardiovascular disease.
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
None

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1948 to Jan 1949, that I last saw the deceased alive on Jan 18 1949, and that death occurred at 2:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE: Paul Stouffer M. D.
23B. ADDRESS: 2301 Annapolis Rd.
23C. DATE SIGNED: Jan. 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/21/49
24C. NAME OF CEMETERY OR CREMATORY: Lewistown
24D. LOCATION (City, town or county) (State): Lewistown, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949
REGISTRAR'S SIGNATURE: Huntington for Williams, Mgr
25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 150

937

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70721 V 331 G70721

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Miss Margaret Dutt

2. DATE OF DEATH: Jan 18 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 216 N. Ann St. 2-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	9 5 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: No History
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Thrombosis	
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Cerebral Hemorrhage	
	DUE TO	
	(C) Hypertension & Arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 21, 1948 *to* Jan 18, 1949, *that I last saw the deceased alive on* Jan 18, 1949, *and that death occurred at* 8 45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul Ferone M. D.
23B. ADDRESS: [illegible]
23C. DATE SIGNED: 1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: Jan. 21 49
24C. NAME OF CEMETERY OR CREMATORY: St Stanislaus
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Fred W. Ogrezinski
ADDRESS: 1900 Eastern Ave

VS 150

83a

Correct age is especially important. Physician: please write the cause of death clearly and fully.

G70722 #24 Prem Twin B.C. 49-10298 ✓ 760.5 G70722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl" Mayo
2. DATE OF DEATH: JAN 13 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-7
c. Length of stay in Baltimore: Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 1700 Llewellyn Ave
5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 1-7-49
9. AGE (If under 1 year, last birthday): If Under 1 Year: Months, Days: 6; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: David Lee Booker
14. MOTHER'S MAIDEN NAME: Virginia Mayo
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Ca 24 hrs
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-7-1949 *to* 1-13-1949 *that I last saw the deceased alive on* 1-13, 1949 *and that death occurred at* 6 Hr a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm H. Finkbeiner M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: Jan 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hoy Deforal
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: ADDRESS:

VS 150

160a

G70723 #2K B.Cert 49-02766 ✓ 76215 G70723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70723

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby "Girl" Stapleton
2. DATE OF DEATH: JAN 13 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 7 hours (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-1
D. STREET ADDRESS (If rural, give location): 908 S. Ellwood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White		1-12-49			7

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Vernice Stapleton
14. MOTHER'S MAIDEN NAME: Frances Kennedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 5 1/2 hrs

DUE TO

(B) prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 1-12-, 1949, *to* 1-13-, 1949, *that I last saw the deceased alive on* 1-13, 1949, *and that death occurred at* 2:30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm H. Zinkham M. D.	JOHNS HOPKINS HOSPITAL	Jan 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
		Forest Dest.	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 20 1949	Huntington Williams, M.D.		

VS 150

159

collect age is especially important. Physician: please write the cause of death clearly and legibly.

G70724 H H 4.W. Disposal BC-B-2099 ✓ 757.3 G70724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70724

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby "Boy" Thompson

2. DATE OF DEATH: JAN 1 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. — Mos. — Days 24

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-2

D. STREET ADDRESS (If rural, give location): 913 E. Madison St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored		12-21-48		24	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Moses Thompson

14. MOTHER'S MAIDEN NAME: Genieve Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
				JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SEPTICEMIA, Rs. PYOCYANEOUS — INTERVAL BETWEEN ONSET AND DEATH: 18 days

DUE TO

(B) cong. abnormality of bladder

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 12-21-, 1948, *to* 1-14-, 1949, *that I last saw the deceased alive on* 1-14, 1949, *and that death occurred at* 3:0 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allen C. Mermann, M. D.	JOHNS HOPKINS HOSPITAL	1-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Hoy Burial	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 20 1949	Huntington Williams, M.D.		

VS 150

157 H

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Exact age is especially important.

G70725 ✓ 420.0 G70725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ADA TUCKER
2. DATE OF DEATH: January 19, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-2
D. STREET ADDRESS (If rural, give location): 1130 Wilmer Court
5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: July 12, 1901
9. AGE (In years last birthday): 47 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laundry worker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Wesley Tucker
14. MOTHER'S MAIDEN NAME: Charity Evans
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bessie Wilson ADDRESS: 1124 Wilmer Court

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B) History of diabetes mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/22/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): A-9-60 Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
FUNERAL DIRECTOR AND ADDRESS: Wm A Jackson 916 Lemmon Ave

VS 151

61

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70726 ✓ 156 G70726

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mr. George Trautner

2. DATE OF DEATH: 18 Jan. 1944

3. PLACE OF DEATH: A. Baltimore City, Maryland Church Home + Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hospital

c. Length of stay in Baltimore: Life resident (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-2
D. STREET ADDRESS (If rural, give location): 4618 Walther ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	white	widowed	4 July 1875	73	6 14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Metalworker	Metal	Balto. Md	U.S.A.

13. FATHER'S NAME: John Trautner

14. MOTHER'S MAIDEN NAME: Mary Ruesler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Mr. Geo Trautner ADDRESS: 4618 Walther

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Liver — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosl. heart disease - calcified valves + cardiac enlargement

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
18 Jan 1949	Disseminated carcinoma of liver	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6 Jan. 1949 *to* 18 Jan. 1949 *that I last saw the deceased alive on* 18 Jan 1949, *and that death occurred at* 2 45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
F. Robert Haase M.D.	Church Home + Hosp	18 Jan 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	1/22/49	Oak Lawn	7225 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 20 1949	Huntington Williams, MD	Clarence F. Hoffmann	1639 Broadway

VS 150

46F

420.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 670727 Registered No. 670727

1. NAME OF DECEASED (Type or Print): RACHAEL JAFFE
2. DATE OF DEATH: 1-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 406 No Broadway
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-5
D. STREET ADDRESS (If rural, give location): 406 No Broadway

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 78 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Benjamin
14. MOTHER'S MAIDEN NAME: Leah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Shirley Jaffe ADDRESS: 406 No Broadway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arterio Sclerotic heart disease
DUE TO
(B) hypertensive dev. resp. kidney
DUE TO
(C) general arterio Sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: 5 years / Some

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-4-1948 to 1-19-1949 *that I last saw the deceased alive on* 1-19-1949, *and that death occurred at* 1:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. A. Michelson M. D.
23B. ADDRESS: 2230 Eutaw Pl.
23C. DATE SIGNED: 1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-20-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run
24D. LOCATION (City, town, or county): Balto (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

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G70728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

156

G70728 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sophye Berman

2. DATE OF DEATH: January 19 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 3803 Fordleigh Road 27-20

c. Length of stay in Baltimore: 50 Yrs. Mos. Days

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED OR DIVORCED (Specify): [redacted]

8. DATE OF BIRTH: 3-28-98 | 9. AGE (In years last birthday): 50 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elias Sacalow

14. MOTHER'S MAIDEN NAME: Fanny Dampole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) chlemia

DUE TO

(B) Carcinoma of liver

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4+ mo.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-20 1948, *to* 1-14 1949, *that I last saw the deceased alive on* 1-19 1949, *and that death occurred at* 3:55 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. W. Smith M.D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-20-49

24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel

24D. LOCATION (City, town, or county): Balto (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

FUNERAL DIRECTOR: Jack Levin Inc

ADDRESS: 2100 Eutaw Pl

VS 1&0

46F

G7O729 ✓ 420.1 G7O729

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James S. Kearney

2. DATE OF DEATH: 1/18/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 N. Calvert St

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 40 N. Calvert St 20-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	married	May 23, 1903	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Book Binder	Young & Seldon	Laurel, Md.	

13. FATHER'S NAME: James Kearney

14. MOTHER'S MAIDEN NAME: Elsie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Margaret M. Kearney	Balto., Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
P. J. Sulzinski M.D.		1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/21/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 20 19[illegible]	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 151

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G70730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1 G70730

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): OLAF C. COONS

2. DATE OF DEATH: January 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY Baltimore

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 10 yrs. (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): Windsor Mill Road, Rt. 5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
male	white	Married	Aug. 23, 1893	55 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-	Lehigh Con. Co.	Lisbon, N. Y.	

13. FATHER'S NAME: John C. Coons

14. MOTHER'S MAIDEN NAME: Cora Randles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mrs. Isabelle M. Coons	Windsor MillsRd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis.

DUE TO Coronary arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* AUTOPSY (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Jan. 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1/20/49		Canandaigua N. Y.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS

VS 1-47

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G70731 ✓ x 443 G70731

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) MRS. Lydia B. BRACKETT

2. DATE OF DEATH Jan 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Minnesota B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Minneapolis

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

D. STREET ADDRESS (If rural, give location) 3021 Idaho Avenue

c. Length of stay in Baltimore 29 days (Yrs. Mos. Days)

6. SEX Female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH April 19 1880 | 9. AGE (In years last birthday) 68 | If Under 1 Year: Months 9, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Iowa | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Albert H. Hale | 14. MOTHER'S MAIDEN NAME Lydia Furtney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Union Memorial Hosp. Records ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular Disease — DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 12± hours

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 18, 1949 *to* Jan 18, 1949 *that I last saw the deceased alive on* Jan. 18, 1949 *and that death occurred at* 10 ~~P~~ A.M., *from the causes and on the date stated above.*

23A. SIGNATURE N. F. Cox 3rd M. D. | 23B. ADDRESS Union Memorial Hospital | 23C. DATE SIGNED 1-18-49

24A. (BURIAL) CREMATION REMOVAL (Specify) Removal | 24B. DATE 1/20/49 | 24C. NAME OF CEMETERY OR CREMATORY — | 24D. LOCATION (City, town, or county) (State) Minneapolis, Minn.

DATE RECEIVED BY LOCAL REGISTRAR JAN 20 1949 | REGISTRAR'S SIGNATURE Emerson Williams, M.D. | 25. FUNERAL DIRECTOR John O. Mitchell & Sons ADDRESS 1900 Eutaw St.

VS 150

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481273 ✓ 332 G70732

BIRTH NO. 70732

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70732

1. NAME OF DECEASED (Type or Print): William Wongus

2. DATE OF DEATH: JAN 18 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore. 16-2
D. STREET ADDRESS (If rural, give location): 1214 N Parrish, St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	single	3-29-98	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Md	

13. FATHER'S NAME: Thomas Wongus

14. MOTHER'S MAIDEN NAME: Claire Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO
(B) unknown

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: terminal bronchopneumonia

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/13/49	small thrombi, cerebral arteries	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 1-10- 1949 to 1-18- 1949, that I last saw the deceased alive on 1-18- 1949, and that death occurred at 7:15 A m. from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Maurice Soltzer M. D.	JOHNS HOPKINS HOSPITAL	1/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	1-22-49	Balto. Mt. Cem.	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 20 1949	Curtis Williams, M.D.	Elroy O. Wilson	1000 Brantly Way

VS 150

8 3 B

Please write clearly and correct age is especially important. Physician: please write the cause of death clearly and fully.

✓ 416

G70733 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70733 Registered No.

1. NAME OF DECEASED (Type or Print): CLIFTON ARTHUR DUGENT.

2. DATE OF DEATH: Jan 19, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 2820 Windsor Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2820 Windsor ave.

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 15-49
D. STREET ADDRESS (If rural, give location): 2820 Windsor Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	W Enter	Married.	1885	about 64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Storekeeper	B+O. Rail Road.	Easton Store. Md.	U.S.A.

13. FATHER'S NAME: Arthur Dugent.

14. MOTHER'S MAIDEN NAME: Agnes A. Ebert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes Spanish Am. War	205-10-0914	Marguerite Stewart	209 Yuma Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Chronic Myocarditis	2 yrs
DUE TO	Rheumatic Cardio Vascular Disease	20 yrs
(B)	Coronary insufficiency	6 mos.
DUE TO		
(C)	Cardiac failure	6 mos.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1948 to Jan 19, 1949, *that I last saw the deceased alive on* Jan 19, 1949, *and that death occurred at* 5 30 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jos. L. Robinson M. D.	833 Fulton Ave	Jan 20 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 22 1949	New National	Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 20 1949 VS 150	Huntington for Williams, M.D.	Walter R. McNamara	4114 Frees Road

93c

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

670734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

670734

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): SAMUEL L. SCOTTEN

2. DATE OF DEATH: January 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-6
D. STREET ADDRESS (If rural, give location): 611 Fortview Way

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Married	August 4, 1903	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pressman

10B. KIND OF BUSINESS OR INDUSTRY: Lord Balto. Press

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Levi Scotten

14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 218-07-0152

17. INFORMANT: Mrs. Elizabeth Scotten ADDRESS: 611 Fortview Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of skull with intracranial hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street--public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 26/6 Dundalk Avenue, 27' N. of O'Donnell St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 15, 1949 8 P.m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Carl L. Voigt M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-22-49

24C. NAME OF CEMETERY OR CREMATORY: St. Mary's

24D. LOCATION (City, town, or county) (State): Hampden

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Paul E. Chenowith Jr. ADDRESS: 3615-17 Eastern Ave

VS 151

170C

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

H2H4E ✓ + 154.1 G70735

G70735 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret Seaton

2. DATE OF DEATH: JAN 20 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: N. C.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): High Point
D. STREET ADDRESS (If rural, give location): 211 Pine St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White		11-11-47	1	14			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		D. C.	

13. FATHER'S NAME: Fred Seaton

14. MOTHER'S MAIDEN NAME: Helen Spencer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CONG. MALFORMATION OF HEART	14 mos.
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CEREBRAL VASCULAR ACCIDENT	8 mos

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 1-14- 1949 *to* 1-20- 1949 *that I last saw the deceased alive on* 1-20 1949 *and that death occurred at* 3:05 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Alan C. Mermann M. D.	JOHNS HOPKINS HOSPITAL	1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	1/20/49		Washington D.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 20 1949	Huntington Williams, M.D.	H. H. Chambers	Washington, D.C.

VS 150

157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. If correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 581.0

Registered No. G70736

BIRTH NO.

1. NAME OF DECEASED (Type or Print): THEODORA DENNIS (alias THEODORA FERGUSON)

2. DATE OF DEATH: January 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 914 East Pratt Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 914 East Pratt Street 3-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	divorced	?	30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
waitress	restaurant	Bangos Maine	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pancretitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Fatty degeneration of liver

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Emil L. Beyer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Jan. 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	Jan. 20, 1949	New Cathedral Cemetery	Old Frederick Rd., Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR ADDRESS: Frank Della Noce, 322 S. High Street

VS 151

128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

✓ 260

G70737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70737
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Schmidt

2. DATE OF DEATH: Jan.17,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3900 Pinkney Road
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 3900 Pinkney Road. 27-20

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	June 16,1883	65 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Captain,	B.C.Fire Dept.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: John Schmidt,

14. MOTHER'S MAIDEN NAME: Marie Krause

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mrs.Lena Schmidt.3900 Pinkney Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetic Coma — INTERVAL BETWEEN ONSET AND DEATH: 48hrs.

DUE TO

(B) Diabetes Mellitus — 10 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/17, 19 49 *to* 1/17, 1949 *that I last saw the deceased alive on* 1/17, 19 49 *and that death occurred at* 2.20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. H. Dermott M.D. M. D.	1136 Poplar Grove St.	1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	Jan.22,1949	Druid Ridge	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

FUNERAL DIRECTOR: C. Vernon Lemmon — ADDRESS: 4611 Park Heights.

45-150

61

G70738

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70738

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROBERT RAYMOND KELLY

2. DATE OF DEATH: January 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New York
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New York
D. STREET ADDRESS (If rural, give location): 347 W. 4th Street

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	White	Married	Jan 2nd 1923	26	0	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Knockabout	Merchant Seaman	Texas	

13. FATHER'S NAME: Robert J. Kelly

14. MOTHER'S MAIDEN NAME: Blanche (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
Not Known		Mrs. Lena Robinson 3814 W. 73rd St. N.Y.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage

DUE TO

(B) Ruptured Liver, Spleen

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Left Kidney

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Multiple Fractures

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] ~~CAUSE OF~~ DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street-public	Pulaski Highway Balto. Co.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
January 18, 1949 p.m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Auto overturned--driver

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
[signature] M.D.	[X]	1-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	1/20/49	GREENMOUNT	BALTIMORE MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 20 1949	Huntington Williams, M.D.	Wm Gar Inc.	1217 St Paul St.

VS 151

1700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70739
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

754.4 H93 Registered No. G70739

1. NAME OF DECEASED (Type or Print): Jacquelyn Legates — Legates
2. DATE OF DEATH: January 19, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston Caroline County.
D. STREET ADDRESS (If rural, give location)
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: 9-19-48
9. AGE (In years last birthday): — If Under 1 Year: Months 4 Days — If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Legates
14. MOTHER'S MAIDEN NAME: Miriam Engrahm
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Septicaemia	5day
DUE TO		
(B)	Pneumonia	14day
DUE TO		
(C)	Cong. heart disease	life

— ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-12 1949 *to* 1-19 1949 *that I last saw the deceased alive on* 1-19 1949 *and that death occurred at* 5 LA P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: a. c. Long M. D.
23B ADDRESS: JOHNS HOPKINS HOSPITAL
23C DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-21-49
24C. NAME OF CEMETERY OR CREMATORY: JR. U.A. Mechanics Cem.
24D. LOCATION (City, town, or county) (State): PRESTON - MD.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR — ADDRESS: John O. Mitchell & Sons. 1900 Eutaw Pl.

VS 150

1576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correct age is especially important. Physician: please write the cause of death clearly and fully.

420.0

G70740

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70740

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr ADAM MICHALAK

2. DATE OF DEATH 1/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSP

c. Length of stay in Baltimore - LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1246 S. DECKER AVE.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months Days	If under 24 hours: Hours Min.
M	W		DEC 21 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY FIREMAN

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? ND

13. FATHER'S NAME MARTIN MICHALAK

14. MOTHER'S MAIDEN NAME AGNES —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROTIC HEART DISEASE - ENLARGED HEART
DUE TO AURICULAR FIBRILLATION
(B) GRADE II DECOMPENSATION
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/15 1949 *to* 1/19 1949 *that I last saw the deceased alive on* 1/19 1949, *and that death occurred at* 10 40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Arnold W. Mutzer M. D.

23B. ADDRESS CHURCH HOME & HOSP

23C. DATE SIGNED 1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Jan 22 1949

24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus

24D. LOCATION (City, town, or county) (State) Dundalk Ave Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 20 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John J. Duda

ADDRESS 2824 Hudson St.

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

67074 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 67074 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (MORCIN) MARCIN (LINARLOWICZ) LENARTOWICZ

3 (b) If veteran, name war: 1ST war Polish Army
3 (c) Social Security Account No. 217-09-0313

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 20, 1873

8. AGE: Years 75 | Months 2 | Days 6 | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual Occupation: Baker
11. Industry or business: 900 Blk. E. Lombard St.

FATHER
12. Name: Anthony Lenartowicz
13. Birthplace: Poland

MOTHER
14. Maiden Name: Maryanna
15. Birthplace: Poland

16 (a) Informant: Passport
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-49 (month) (day) (year)
(c) Cemetery or ~~XXXXXXX~~ Sacred Heart of Mary
Location: Baltimore County, Maryland

18 (a) Funeral director: JOHN M. WEBER
(b) Address: 401 S. Chester Street

19 (a) JAN 20 1949 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 19 49 at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death.)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. H. Sullivan M.D. Medical Examiner.
Date signed 12/26/49

G.0742 ✓ 331 G.0742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

● PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. ● The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 930 n Central av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 930 N. Central av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Noah Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Mary Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-24-[illegible]

8. AGE: Years	Months	Days	If less than one day
75	8	23	hr. min.

9. Birthplace Somerset Co. Md (Town, county, and state)
10. Usual Occupation Common work
11. Industry or business

FATHER	12. Name William Thomas
	13. Birthplace Somerset Co Md
MOTHER	14. Maiden Name Mirah Miles
	15. Birthplace Somerset Co Md

16 (a) Informant Mary Thomas
(b) Address 930 n Central av
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21, 1949 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon Location Baltimore City
18 (a) Funeral director Lottie Gross
(b) Address 1408 Ashland ave
19 (a) JAN 20 1949 (Date received by Registrar) (b) Entered for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1949 at 6 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1948 to Jan 17 1949. and that I last saw h[illegible] alive on Jan 15 1949.

Immediate cause of death: Cerebral Hemorrhage — Duration 5 mo
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher M. D.
Address 1622 Monument Date signed 1-18

VS 860

83a 44

V X 422.1

G70743

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70743

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William H. DeBaufre

2. DATE OF DEATH: January 17-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinecrest Sanitorium

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 7608 Old Battle Grove Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If less than 1 year last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Sept. 20. 1893	75	3	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Balto. Md.	

13. FATHER'S NAME: James DeBaufre

14. MOTHER'S MAIDEN NAME: Leanora Ringrose

15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — ADDRESS: Marie DeRenzy - 3701 E. Chase St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Chronic Myocarditis & Myocardial Degeneration	Unknown
DUE TO (B)	Generalized Arteriosclerosis	Unknown
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December 6, 1948, *to* January 17, 1949, *that I last saw the deceased alive on* Jan. 17, 1949, *and that death occurred at* 8.45P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Melvin N. Borden M. D.	2030 W. Fayette St.	1/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 21. 1949	Parkwood	Taylor Ave - Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 20 1949	Huntington Williams, M.D.	John C. Milly Inc. - 2435 E. Oliver St

VS 150

93D

REGARDING WHITE LEAD: UNLOADING INS. Every item of information should be carefully supplied. Use correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70744 ✓ 422.1 H10 G70744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John or JAN OLSZEWSKI 2

2. DATE OF DEATH JAN 19 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1004 S. KENWOOD AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO 1-4

c. Length of stay in Baltimore 65 yrs. Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1004 S. KENWOOD AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	WIDOWED	MAY. [illegible]	82				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Laborer

10B. KIND OF BUSINESS OR INDUSTRY Mc Shane

11. BIRTHPLACE (State or foreign country) GERMANEY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME undown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Marta Smolinska ADDRESS 2727 Loudoun

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-sclerosis — INTERVAL BETWEEN ONSET AND DEATH: Undetermined

DUE TO

(B) Chronic Bilateral Bronchitis — Undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Myocardial Insufficiency — 10 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic mitral regurgitation — Undeter.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 3 19 49 to Jan. 18 19 49 *that I last saw the deceased alive on* 1-18- 19 49 *and that death occurred at* 1:35 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE R. A. Bronshar M. D.

23B. ADDRESS 2037 Boswell St.

23C. DATE SIGNED 1-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Jan 22/49

24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem

24D. LOCATION (City, town, or county) (State) Dundalk ave

DATE RECEIVED BY LOCAL REGISTRAR JAN 20 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Stephen J. Balkowski ADDRESS Inc 1000 S. Kenwood ave

VS 150

926

443

G70745
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70745

1. NAME OF DECEASED (Type or Print): WALTER PERRY CORIA

2. DATE OF DEATH: Jan. 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 203 Hawthorn Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 203 Hawthorne Rd.

c. Length of stay in Baltimore: 43 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 203 Hawthorne Rd. 27-14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
male	white	widowed	Feb. 23, 1862	86 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): manager

10B. KIND OF BUSINESS OR INDUSTRY: Lykes Bros. S. S. Co

11. BIRTHPLACE (State or foreign country): Mass.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jos. Coria

14. MOTHER'S MAIDEN NAME: Joanna Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 218-10-9759

17. INFORMANT: Mrs. Jessie W. Pierce ADDRESS: 203 Hawthorne Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Cerebral Hemorrhage	24 hrs
DUE TO (B)	Hypertension Arteriosclerotic Disease	5 yrs
DUE TO (C)		

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 13, 1949 *to* Jan 18, 1949 *that I last saw the deceased alive on* Jan 18, 1949 *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: FRITZ J. KIMZEY M. D.

23B. ADDRESS: 2700 Hartford Rd

23C. DATE SIGNED: Jan 20 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/21/49

24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.

24D. LOCATION (City, Town, or County) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949

REGISTRAR'S SIGNATURE: Deputy for Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

937

Please write plainly; use ink; do not use pencil. Be sure that the information supplied for each question is complete and correct. Physician: please write the cause of death clearly and legibly.

G70746 ✓ 331 G70746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John E. Stansbury

2. DATE OF DEATH: 1/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 321 S. Collins Ave.

3B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp.

3C. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: Male
6. COLOR or RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 4, 1879
9. AGE (In years last birthday): 69 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): Harford Co., Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Stansbury
14. MOTHER'S MAIDEN NAME: Elizabeth Bull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mr. James Stansbury
ADDRESS: Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 3/4 hrs.
DUE TO
(B) Hypertension & Arteriosclerosis — many years.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
None

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 1/19, 1949 *to* 1/19, 1949, *that I last saw the deceased alive on* 1/19, 1949, *and that death occurred at* 10:47 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John Paul Young M. D.
23B. ADDRESS: West Balto. Gen. Hosp.
23C. DATE SIGNED: 1/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/22/49
24C. NAME OF CEMETERY OR CREMATORY: St. Margaret's Cem.
24D. LOCATION (City, town, or county) (State): St. Margaret's, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

CN. 125980

BIRTH NO. G70747

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 002 011 G70747 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print) Christopher Dunn

2. DATE OF DEATH 1- 19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore 8 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4325 York RD. 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	S	Jan. 27-1912	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		England	

13. FATHER'S NAME Frank Dunn (D)

14. MOTHER'S MAIDEN NAME Elizabeth Young (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Records Balto. City Hospitals	4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) For Advanced Pulmonary Tuberculosis	1 year +
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Tuberculous enteritis. Secondary	2 mo.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1 - 11 , 1949 *to* 1-19-49 , 1949 *that I last saw the deceased alive on* 1 - 19 , 1949 *and that death occurred at* 7:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Margaret A. Morgan M. D.	Baltimore City Hospital	1-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	January 21/49	New Cathedral	Old Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 20 1949	Lucien Williams, M.D.	John C. Moran	3000 E. Baltimore St.

13 B

G70748

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 120.1 G70748

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mamie E. Adams

2. DATE OF DEATH: 1-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: 27 ~~Yrs.~~ ~~Mos.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Frederick
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buckeystown
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	married	May 31. 1882	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		MARYLAND	

13. FATHER'S NAME: James White

14. MOTHER'S MAIDEN NAME: Mary Pearl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Charles E. Adams	Buckeystown - MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cardiac failure, myocardial infarction massive	40 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Coronary sclerosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	DUE TO (C) Encephalitis	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
Jan. 3rd 49	None	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 23, 1948 *to* Jan. 19, 1949, *that I last saw the deceased alive on* Jan 19, 1949, *and that death occurred at* 5:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Fred C. McClintock, M. D.	University Hospital	1-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-23-49	Mt. Olivet - Frederick Md	Frederick Md.

DATE RECEIVED BY REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Washington Williams, M.D.	M. R. Etchison & Son	Frederick Md

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G70749 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 N — G70749 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): IDA K. SCHWARTZ

2. DATE OF DEATH: Jan. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2609 E. Fairmont Ave.
c. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2609 E. Fairmont Ave. 6 - 0 r

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	White	Married	Feb. 23, 1881	67	10	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Klotsch	Elizabeth Frank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	William F. Schwartz	2609 E. Fairmont Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	cerebral hemorrhage	7 days
DUE TO (B)	Hypertension	5 years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-13- , 1949 *to* 1-18- , 1949, *that I last saw the deceased alive on* 1-18- 1949 *and that death occurred at* 10:45 *P.* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benj. B. Moore, M.D.	448 N. Luzerne Ave	1-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/22/49	Woodlawn	Woodlawn, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huntington Williams, M.D.	William Cook, Inc	1217 St/Paul St.

VS 150

83a

GM. 106276 ✓ 151

G70750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70750

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) William George Furlong

2. DATE OF DEATH 1- 19- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 127 S. Clinton St. 26 14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	W	June 24- 1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	U.S.

13. FATHER'S NAME Guy ? (D)

14. MOTHER'S MAIDEN NAME Louise Minor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Records Balto. City Hospitals ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF STOMACH

DUE TO WITH METASTASIS TO LIVER

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NONE		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-21-, 1946 *to* 1-19, 1949, *that I last saw the deceased alive on* 1-19, 1949 *and that death occurred at* 2:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas P. Jennings M. D.	BALTIMORE CITY HOSPITALS	1-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/20/49	Oak Lawn	Rosedale MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Hunter for Williams, M.D.	Wilhom & Son	1217 E. Fayette St

VS 150

463

G70751 ✓ 422.1 G70751

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): MARY CECELIA O'DONNELL

2. DATE OF DEATH: Jan. 19-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 309 Illchester Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 309 Illchester Ave. 1 2 3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widow	May 16,1869	79	8 3	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore,Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Hughes	Mary F. Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No	None	Miss Ketherine O'Donnell,309 Illchester Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio Vascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1949 *to* Jan 19, 1949 *that I last saw the deceased alive on* January 19 1949 *and that death occurred at* 9:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William J. Helfrich M. D.	5006 Roland Ave - 10	1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/22/49	New Cathedral	Baltimore,Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 21 1949	Huntington Williams, M.D.	William Cook, Inc.,1217 St.Paul St.

VS 150

937

G70752 ✓ 491 G70752

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): ANNIE R. HILD

2. DATE OF DEATH: Jan. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 417 West 26th Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 417 W. 26th Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widow	March 19, 1863	85	10		0	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		New Market, Md.	

13. FATHER'S NAME: (Unknown) Sullivan

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	Mrs Dessa Grisinger, 417 W. 26th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Bronchopneumonia

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 17, 1949, *to* Jan 19, 1949, *that I last saw the deceased alive on* Jan 19, 1949, *and that death occurred at* 6P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	8429 Overton Ct	Jan 20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	1/22/49	Monkton, M.E., Monkton, Md	Monkton, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 21 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

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C70753 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

016 Registered No. C70753

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print): Charles A. Piquett

2. DATE OF DEATH: Jan. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 404 Edgewood Street
c. Length of stay in Baltimore: 68 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 404 Edgewood Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	Jan. 1, 1881	68	0 / 18	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -----
10B. KIND OF BUSINESS OR INDUSTRY: -----
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John P. Piquett
14. MOTHER'S MAIDEN NAME: Louisa Lipp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mary A. Piquett ADDRESS: 404 Edgewood St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Intercalosis of bladder + kidneys — 3-4 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 2, 19 48 *to* Jan. 19, 19 49, *that I last saw the deceased alive* Jan. 19, 19 49, *and that death occurred at* 9:25 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm E. Nelson, M.D.
23B. ADDRESS: 3 W. Biddle St
23C. DATE SIGNED: 1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/24/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): oodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. W. Meads and Son ADDRESS: 703 N. Calvert St.

VS 150

20

G707.54 ✓ 584 G707.54

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Weber, Lula

2. DATE OF DEATH 1-20-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2529 Kirk Ave. 9-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Married	9-9-1895	53	4	11	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward McCurley

14. MOTHER'S MAIDEN NAME Emma Berry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO None

17. INFORMANT John C Weber ADDRESS 2529 Kirk Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cholecystectomy + — 2 wks

DUE TO ACUTE PANCREATITIS

(C) Arteriosclerotic Ht. Disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION? 1-12-48 49?

19B. MAJOR FINDINGS OF OPERATION Chronic Cholecystitis Cholelithiasis

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 6 1949 *to* Jan 20, 1949 *that I last saw the deceased alive on* Jan 20, 1949, *and that death occurred at* 5:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Joseph B Schwab M. D.

23B. ADDRESS Franklin Sq Hosp

23C. DATE SIGNED Jan 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Jan. 24, 1949

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 21 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR George L. Schwab ADDRESS 2101 Frederick Ave

VS 150

126

G70755 ✓ 416 G70755

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print): JOSEPHINE KASPER

2. DATE OF DEATH: JANUARY 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 4002 SOUTHERN AVE.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 4002 SOUTHERN AVENUE 77-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
FEMALE	WHITE	MARRIED	SEPT. 10, 1919	29	4	8	–	–

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	BALTO., MARYLAND	U.S.A.

13. FATHER'S NAME: SALVATORE BARRACATO

14. MOTHER'S MAIDEN NAME: ROSA GUERCIO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
NO ******		STEVE J. KASPER	4002 SOUTHERN AVENUE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO

(B) Rheumatic Cardiovascular Disease — Unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 18, 1949, *to* Jan 18, 1949, *that I last saw the deceased alive on* Jan 18, 1949 *and that death occurred at* 6:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Adams Kerr Swiss M. D.	6732 Dalcen Rd	June 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JAN. 22, 1949	LOUDON PARK CEMETERY	BALTIMORE, MARYLAND

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huntington Williams, M.D.	GEO. L. SCHWAB	2101 FREDERICK AVENUE

VS 150

93c

G70756 ✓ 331 G70756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Emma Elizabeth Hodes

2. DATE OF DEATH: January 19th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 725 E. 21st. St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 85 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 725 E. 21st. St. 9-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	November 15, 1863	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Baltimore Md.	U. S.

13. FATHER'S NAME: Unknown Kuhlman

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Miss Irma E. Hodes	725 E 21st. St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized arteriosclerosis — Indefinite

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Jan 9, 1947 *to* Jan 19, 1949 *that I last saw the deceased alive on* Jan 17, 1949 *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathaniel M Beck M. D.	1004 E 21st St	Jan 21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 22nd. 1949	Parkwood Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Hughston Williams, M.D.	Geo. L. Beyer Jr.	1512 Hollins St.

VS 150

83a

G707:57 ✓ 756.2 G707:57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-01220 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print): Baby Stern "B"

2. DATE OF DEATH: January 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore, Inc.
c. Length of stay in Baltimore: 5 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1909 Gwynns Falls Parkway 15-4

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: January 6, 1949
9. AGE (In years last birthday) | If under 1 year: Months | Days: 6 | If under 24 hours: Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Erwin Simon Stern
14. MOTHER'S MAIDEN NAME: Jeanette Schnitzer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mother - Mrs. Jeanette Stern ADDRESS: 1909 Gwynns Falls Pkwy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Tracheo Oesophageal Fistula	5 days
DUE TO	Congen Malformation	
(B)	Imperforate Anus, & Recto Urethral Fistula	5days
DUE TO	Congen Malformation	
(C)	Bronchopneumonia	4 days.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 7, 1949 *to* Jan 12, 1949 *that I last saw the deceased alive on* Jan 12 1949, *and that death occurred at* 3:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Sydney A Warren M. D.
23B. ADDRESS: Sinai Hospital Baltimore
23C. DATE SIGNED: Jan 14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School
24D. LOCATION (City, town, or county) (State) JAN 18 1949

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 450

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G707:58

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

431 G707:58

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): MARY C. PHELPS

2. DATE OF DEATH: Jan. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2311 Mosher St.

C. Length of stay in Baltimore: Yrs. 16 Mos. Days 05

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2311 Mosher St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	Feb. 22 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md	

13. FATHER'S NAME: Francis T. Hann

14. MOTHER'S MAIDEN NAME: Hanna W. Winters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Walter K. Phelps	2311 Mosher St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocarditis & Generalized Anemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 16 weeks

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/15, 1949 *to* 1/19, 1949 *that I last saw the deceased alive on* 1/19, 1949, *and that death occurred at* 5:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Cohnan M. D.	1911 W North Ave	1/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/22/49	Loudon Park	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huntington Williams, M.D.	Martin Fahey & Sons	1827 W. North Ave.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G707:59

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 E. Lexington St. 5-07
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caleb Estep

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
67 ?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School JAN 4 1949

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 21 1949 (Date rec'd by registrar) [illegible] for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1948, at 5.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1948 to Dec. 17 1948, and that I last saw him alive on Dec. 17 1948.

Immediate cause of death Senile malnutrition — Duration

Due to cardiac cause

Due to

Other Conditions Hypertension & arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vieler M.D.
Address Balto City Hosp Date signed 3 Dec 48

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G70760 25-15656

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

450.0 G70760

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): William Chamberlain

2. DATE OF DEATH: Jan. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2719 Penn Ave. (NO HOME) 12-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widow	May 25, 1876	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John A.

14. MOTHER'S MAIDEN NAME: Rebecca Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: RECORDS-BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) GENERALIZED ARTERIOSCLEROSIS — 10 YEARS

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NONE		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-25-28, 19__, *to* 1-7-, 1949, *that I last saw the deceased alive on* 1-7-, 1949, *and that death occurred at* 2:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas P. Jarvinger M. D.	BALTIMORE CITY HOSPITALS	1-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	JAN 17 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 21 1949	Huntington Williams, M.D.	Commissioner of Health

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

107

G70761 456.2 G70761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C. 49-01129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and correct age is especially important.

1. NAME OF DECEASED (Type or Print): FRANK ZACCARI

2. DATE OF DEATH: 1-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: 3 ~~Years~~ Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
307 N. Greene St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 4-2

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 1-17-49
9. AGE (In years last birthday): If Under 1 Year: Months / Days: 3 / If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JAMES ZACCARI
14. MOTHER'S MAIDEN NAME: DORA LAMARTINA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration Pneumonia
DUE TO
(B) Post Operative - C Occlusive Thrombus
DUE TO
(C) Congenital Atresia of Colon

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1-19-49
19B. MAJOR FINDINGS OF OPERATION: Congenital Atresia of Colon - Obstruction
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-19, 1949 to 1-20, 1949 that I last saw the deceased alive on 1-20, 1949 and that death occurred at 5:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE: Talbot C. Rodgers, M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-21-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): Belair Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Frank Della Rose
ADDRESS: 322 S. High St.

VS 150

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G70762 B.C. 4800465 ✓ 762.5 G70762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby of Roa Belle Freeman

2. DATE OF DEATH: 1-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. 1 hr Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-1
D. STREET ADDRESS (If rural, give location): 19-01 332 N Calhoun

5. SEX: M
6. COLOR OR RACE: N
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 1-11-49
9. AGE (In years last birthday) / If under 1 year: Months, Days / If under 24 hours: Hours 11, Min. 22
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N' Born Infant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Roosevelt Freeman
14. MOTHER'S MAIDEN NAME: Roa Belle Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Roa Belle Freeman
ADDRESS: 332 N Calhoun

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Atelectasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO:

(C): Prematurity

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT:

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 11 ~~1949~~ 35 m, 1949 to 8 ~~55~~ 53 m 1-11, 1949 *that I last saw the deceased alive on* 1-11, 1949, *and that death occurred at* 8 ~~55~~ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Howell Cosme M. D.
23B. ADDRESS: 1131 Harlem Ave
23C. DATE SIGNED: 1/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: [redacted]
24D. LOCATION (City, town, or county) (State): JAN 18 1949

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
[redacted] Commissioner of Health
ADDRESS

VS 150

159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

C70763

BALTIMORE CITY HEALTH DEPARTMENT 223

CERTIFICATE OF DEATH

Registered No. C70763

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Mrs. Rebecca Hildwein

2. DATE OF DEATH: January 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hosp

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2040 E. Hoffman Street 8 07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last Birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Fe.	White	Widow	Feb. 27, 1887	61	10	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hwfe.	—	Baltimore, Maryland	

13. FATHER'S NAME: Waybe

14. MOTHER'S MAIDEN NAME: Margaret — —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—	—	none	Mrs Marie Gonce Jr.	2040 E. Hoffman St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningioma of the spinal cord — INTERVAL BETWEEN ONSET AND DEATH: 5 mos. +

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia — several days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-4-48 11-23-48	Spinal cord meningioma.	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/16/48, 19__, *to* 1/20, 1949, *that I last saw the deceased alive on* 1/20/, 1949, *and that death occurred at* 9:05 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Joseph Krejci M. D.	1400 N. Caroline St.	1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 22/49	Loudon Park	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huddington Williams, M.D.	Philip Henry Sons	2024 Orleans St

VS 150

561

6707.4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 Registered No. 6707.4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? 37-49 (Yes or No) If yes, name country

3 (a) FULL NAME SARAH COHEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Laban
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Jonah Cohen
(b) Address Levindale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-49 (month) (day) (year)
(c) Cemetery or crematory Shaar Israel
Location Northern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2120 Eutaw Place

19 (a) JAN 21 1949 (Date rec'd by registrar) (b) Signature of Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20 1949, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1949 to 1-20 1949 and that I last saw h 45 alive on 1-20 1949

Immediate cause of death Cerebral hemorrhage — Duration

Due to arteriosclerosis

Due to

Other Conditions Myocardial fibrosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.

Address Levindale Home Date signed 1-20-49

VS 150

937

G70765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161

Registered No. G70765

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Harry Lesser

2. DATE OF DEATH: Jan. 20-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1171 E. Lombard St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1171 E. Lombard St

c. Length of stay in Baltimore: 45 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1171 E. Lombard St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	1895	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant	Second Hand Clothes	Poland	U.S.A.

13. FATHER'S NAME: Phillip Lesser

14. MOTHER'S MAIDEN NAME: Chig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Rose Lesser - Wife	1171 E. Lombard St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute cardiac dilatation

DUE TO

(B) Ca of Lung

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2 11, 19 49, *to* 1 20, 19 49, *that I last saw the deceased alive on* 1 19, 19 49, *and that death occurred at* 1 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. C Feldman M. D.	443 E Balto	1/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-21-49	Rosedale	Balto. MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Place

VS 150

47a

G70766 GRAJAUSKAS H22.1 G70766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VINCENT J. GRAJAUSKAS (GRAY) (GRAUSKY) — DATE OF DEATH JAN 19-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 28 Parkin St — B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 60 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 28 PARKIN ST B. COUNTY BALTO MD

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE.

D. STREET ADDRESS (If rural, give location) 28 Parkin St. 18 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	P. - 1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Lith	?

13. FATHER'S NAME VINCENT GRAJAUSKAS

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Anna Grajauskas	28 Parkin St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO (B) Chronic myocarditis

DUE TO (C) Arteriosclerosis — 5 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	—	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 20, 1948, *to* Jan 17, 1949, *that I last saw the deceased alive on* 1-18-, 1949, *and that death occurred at* 1:45A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John P. Ulrock, Jr. M. D.	1227 Wash. Blvd	1-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	JAN 24 1949	Holy Redeemer Cem	Belair Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huntington Williams, M.D.	Joseph Kaminskas Inc	602 Wash.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

93)

G70767 ✓ 442 G70767

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Charles Mihon (Mahonaus?)
2. DATE OF DEATH: JAN 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 727 W. Fayette St
C. Length of stay in Baltimore: 40 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 4-07
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 727 W Fayette St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	May 31 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Balt.	?

13. FATHER'S NAME: Charles Mihon
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	215-09-0421	Mary Mihon	727 W Fayette St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute Cardiac Failure	1 da
DUE TO (B)	Cardio Vascular Renal Disease Coronary	
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-10, 1948 *to* 1-19, 1949 *that I last saw the deceased alive on* 1/19, 1949, *and that death occurred at* 11:30 a *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph Lawrence Curtin M. D.	674 Washington Blvd	1/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	JAN 22-1949	Holy Cross Cem.	Arundel County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huntington Williams, MD	Joseph Kasunskes Jr	602 Wash. Blvd

VS 150

131a

G70768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

Registered No. G70768

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Emma Smith

2. DATE OF DEATH: 1/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 641 W Mulberry St
C. Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 641 Mulberry St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto City
D. STREET ADDRESS (If rural, give location): 641 W Mulberry St 4-07

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Sep 24 - 1881
9. AGE (In years last birthday): 67 (If under 1 year: Months; Days; If under 24 hours: Hours; Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: ~~Emma~~ unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: 216-06-4717
17. INFORMANT: John H Smith ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Renal Disease

DUE TO

(B)

DUE TO

(C) Pulmonary Congestion

INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/6 1948 to 1/20 1949, that I last saw the deceased alive on 1/19 1949, and that death occurred at 1 05 p m., from the causes and on the date stated above.

23A. SIGNATURE Wm Garner M. D.
23B. ADDRESS 713 Cong St
23C. DATE SIGNED 1/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE 1/24/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto County

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm A Jackson ADDRESS 916 Penna Ave

937

G70769

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

194 Registered No. G70769

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Catherine Schroeder

2. DATE OF DEATH: Jan. 18 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. Gen. Hosp.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 7200 Windsor Mill Road

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: Jan 25 1894
9. AGE (In years last birthday): 54
If under 1 year: Months / Days
If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John J Meursheim
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Henry Schroeder ADDRESS: 7200 Windsor Mill Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF THYROID

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/18/ , 1949, to 1/18/ , 1949, that I last saw the deceased alive on 1/18/ , 1949, and that death occurred at 9:00 P.m., from the causes and on the date stated above.

23A. SIGNATURE: Leonard A. Golenbock M. D.
23B. ADDRESS: West Balto Gen Hosp
23C. DATE SIGNED: 1/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 22/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem
24D. LOCATION (City, town, or county) (State): Balto Co

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilhelm Funeral Home ADDRESS: 2008 Orleans

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Charles F. W. Kreuzberg

2. DATE OF DEATH: January 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1521 N. Wolfe St. 8 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	single	12/27/1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	

13. FATHER'S NAME: Carl Kreuzberg

14. MOTHER'S MAIDEN NAME: Anna Hacker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Hermine Kreuzberg ADDRESS: 1521 N. Wolfe St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory Failure.
DUE TO
(B) Bilateral bronchopneumonia.
DUE TO
(C) Carcinoma of the parotid gland c metastases (Dr)
Arterio-sclerotic Heart disease.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(1) Generalized Arteriosclerosis
(2) Parotid gland tumor c Metast. & Ant
(3) Fat nutrition.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 14, 1949, *to* Jan 20, 1949, *that I last saw the deceased alive on* Jan 20, 1949, *and that death occurred at* 7:25 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip A. Peter M.D.	1400 N. Caroline St.	Jan 20, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Jan 24/49	Balto Cem	Balto

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Ulman Funeral Home ADDRESS: 2008 Pulaski

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H20.1 G7077

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles Minnegerode (MINNEGERODE)

2. DATE OF DEATH January 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Union Memorial Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. Length of stay in Baltimore 50 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) Charles 931 Ch - 12-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	April-1-1873	75 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	St Louis - Mo.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Minnegerode	Virginia Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—		Mrs Gertrude T. Minnegerode	Charles 931

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I certify that I took charge of the remains described above, held an* Insp & Inquest *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
William G. Helfrich M.D.		1/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Jan-22-49	Sharon Cemetery	Middleburg-Loudon Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR 1/21/1949 LOCAL REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Stuart Morris Co. ADDRESS 108 W North Ave. Balto. M.

JAN 21 1949

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

586 Registered No. G70772

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print) Caroline W. Holland

2. DATE OF DEATH Jan. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Bal. To.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cockeysville
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.		Oct. 5, 1879	69 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife.		Frecerick Co., Md.	

13. FATHER'S NAME Dr. D. E. Stone

14. MOTHER'S MAIDEN NAME Rebecca Owens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Rebecca H. Sutton	Sherwood Rectb Cockeysville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diaphragmatic Abscess
DUE TO Rupture into Bronchus.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Ruptured gall bladder
DUE TO generalized Peritonitis

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-4-49.	Diaphragmatic abscess	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-4-49, 19__, *to* 1-19-49, 19__, *that I last saw the deceased alive on* 1-19-49, 19__ *and that death occurred at* 8:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert A. Hahn, M. D.	University Hosp;	1-20-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/22/49	Central Cem.	Frederick Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1 G70773

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): DOMENICO CULOTTA

2. DATE OF DEATH: Jan. 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1737 W. North Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1737 W. North Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Aug. 28, 1874	74 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): shoe maker

10B. KIND OF BUSINESS OR INDUSTRY: self

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Salvatore Culotta

14. MOTHER'S MAIDEN NAME: Concetta Zito

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Sam Culotta — ADDRESS: 1737 W. North Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: yrs.

DUE TO

(B) Coming Pneumonia — Sudden

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 1 - 49, 19__, to Jan 18 49, 19__, *that I last saw the deceased alive on* Jan 17 49, 19__, *and that death occurred at* 7:30 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: M. D.

23B. ADDRESS

23C. DATE SIGNED: Jan 20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/21/49	Cathedral Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Elvira Moorman
2. DATE OF DEATH: Jan 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 951 Madison Ave
C. Length of stay in Baltimore: 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 951 Madison Ave. 11-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Married	Aug. 11, 1903	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Merchant Va.	

13. FATHER'S NAME: Burrell Harris
14. MOTHER'S MAIDEN NAME: Bella ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Charles Moorman	951 Madison Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic myocarditis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 13, 1949 *to* Jan. 18, 1949 *that I last saw the deceased alive on* Jan. 17, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Campbell M. D.	718 Dolphin St	1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 21/49	Mt. Calvary Cem.	A. A. County Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huntington Williams M.D.	Mrs. Lott A. Elliott & Daughter	1129 N. Caroline St.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Florence E. Lassahn

2. DATE OF DEATH: Jan. 20th, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1318 N. Montford Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1318 N. Montford Ave. 8 04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	married	Oct. 8th, 1898	50	2	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Henry C. Kaiser

14. MOTHER'S MAIDEN NAME: Emma V. Bradley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) Carcinoma - Sigmoid
DUE TO with generalized carcinomatosis
(B)
DUE TO anasarca
(C)

INTERVAL BETWEEN ONSET AND DEATH: 13 mo.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Dec 1948	Carcinoma of Sigmoid	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 1948 *to* Jan 20, 1949 *that I last saw the deceased alive on* Jan 20, 1949, *and that death occurred at* 7:00 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Theodore Kardosh M. D.	114 Medical Arts Bldg	1/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1/24/49	Parkwood	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huntington for Williams, M.D.	Lassahn Funeral Home	7401 Belair Rd.

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46E

G707:6 ✓ X .610 G707:6

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print): Peter Tremper

2. DATE OF DEATH: Jan. 20th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fayette & Calhoun — Franklin Square Hospital
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fullerton, Md.
D. STREET ADDRESS (If rural, give location): 4106 Putty Hill Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Nov. 22nd, 1865	83	1	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	Saloon Keeper	Baltimore County, Md.	U.S.A.

13. FATHER'S NAME: Leonard Tremper

14. MOTHER'S MAIDEN NAME: Catherine Winkler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

15. SOCIAL SECURITY NO

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Uremia	15 days
DUE TO		
(B)	Hydronephrosis, bilateral	?
DUE TO		
(C)	Benign Prostatic Hypertrophy	?
	Arteriosclerotic Heart Disease	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/20/49	Benign Prostatic Hypertrophy	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/5, 1949 *to* 1/20, 1949 *that I last saw the deceased alive on* 1/20, 1949 *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. Fred Hawkins, Jr. M. D.	Franklin Square Hospital	1/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1/24/49	St. Josephs	Fullerton, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Lustington Williams, M.D.	Lassahn Funeral Home	7201 Belair Rd

VS 150

137a

G707.7 ✓ X G707.7

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 193

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): ALDEN "A" ARNOLD

2. DATE OF DEATH: Jan. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Park Drive & 31st St.
c. Length of stay in Baltimore: Yrs. 4 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Michigan
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marine City
D. STREET ADDRESS (If rural, give location): 304 N. Main St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	Nov. 29, 1901	47	1	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Captain	Seafarer	Michigan	USA

13. FATHER'S NAME: Edgar Arnold

14. MOTHER'S MAIDEN NAME: Theresa Kormier

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		yes- ?	Records-USMH- Balto, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Glioblastoma multiforme
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Unknown

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12/16/48 & 12/28/48	Glioblastoma multiforme	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 12, 1948 *to* Jan. 21, 1949, *that I last saw the deceased alive on* Jan. 21, 1949, *and that death occurred at* 6:55 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Sr. Surgeon, Clinical M. D.	US Marine Hospital, Balto, Md.	1/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 24/49	St. Clair, Michigan	St. Clair, Michigan

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huntington Williams, M.D.	Stewart & Mowen Co.	108 W. North Ave.

VS 150

54a City #1.

G707.8

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 9035 N 820

Registered No.

G707.8

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Benjamin Hooper

2. DATE OF DEATH: 1/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Bend Gen Hospital
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 114 E Gittings St 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widower	3/4/1869	79	10 / —	— / —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Baltimore Md	

13. FATHER'S NAME: Joseph Hooper

14. MOTHER'S MAIDEN NAME: Mary V Lightner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs Mueller — ADDRESS: 114 E Gittings

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pneumonia, Hypostatic	5
DUE TO (B)	Fracture, Rt Femur Intertrochanteric	90
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Cirrhosis, Hepatic	?
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

CERTIFICATION APPROVED BY
H. Merrill MD

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION: For: Wm. C. Helfrich M. D.

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ACCIDENT

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.): in front of home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 114 East Gittings Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 10 21 48 ? m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Tripped over the curb

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____ 19__ *and that death occurred at* 4.00a m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: SBGH

23C. DATE SIGNED: 1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/22/49

24C. NAME OF CEMETERY OR CREMATORY: London Park

24D. LOCATION (City, town, or county) (State): Essex Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: D. J. Foley & Sons — ADDRESS: 1318 Light

On Approval

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G707.19

Dr. Conrad Richter
1706 N. Washington

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

426.1 G707.19

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carl William Schmidt

2. DATE OF DEATH: Jan. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2106 Cliftwood Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	Mar. 25, 1903	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ins. Engineer V	Sanborn Map Co.	Baltimore, Maryland	

13. FATHER'S NAME: Charles Schmidt

14. MOTHER'S MAIDEN NAME: Anna Schewe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	067-05-0539	Mrs. M. Schmidt, 2106 Cliftwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hours.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) HYPERTENSION / ANGINA PECTORIS — Hypertension; Angina pectoris

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1/12, 1949, *to* 1/19, 1949, *that I last saw the deceased alive on* 1/19, 1949, *and that death occurred at* 8 24 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Conrad H. Richter, M. D.	1706 N. Washington St	1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-22-49	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 21 1949	H. Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70780

BALTIMORE CITY HEALTH DEPARTMENT 490

CERTIFICATE OF DEATH

Registered No. G70780

BIRTH NO. B.C. 48-17473

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): John P. Martin

2. DATE OF DEATH: 1/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General 90A
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 43 " West St. 23-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
M	C	Single	Sept. ? 1948	—	4			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Martin
14. MOTHER'S MAIDEN NAME: Saraha ?
15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Saraha Martin ADDRESS 43-W West St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Carl L. Rogers M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): 1/22/49
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Cedar Hill. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead
ADDRESS: 918-Druid Hill Ave - 108 Hill Ave

VS 151

✓ 334

G70781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70781 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MISSOURI ELIZABETH FOSTER

2. DATE OF DEATH: 1/19/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 940 W. Franklin St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 940 W. Franklin — 18-21

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Widowed	8/28/1894	54	4	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook	Domestic	Gloucester, Va.	U.S.A.

13. FATHER'S NAME: James Kemp

14. MOTHER'S MAIDEN NAME: Pinkey Dixon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No	-	None	Frank Jones-940 W. Franklin St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension — Unknown

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 16, 1948, *to* Jan 19, 1949, *that I last saw the deceased alive on* Jan 19, 1949, *and that death occurred at* 12:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Garland Shirell Jr M. D.	902 W. Franklin St	1-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/22/49	Arbutus Mem'l. Pk	Balto. County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 21 1949	[illegible]	Charles G. Cooper-512 Carrollton Ave

VS 150

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

G70782 ✓ 422.1 G70782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William CHARLES ENGEL

2. DATE OF DEATH: 1/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 South FULTON
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 42 S. Fulton Ave. 19-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	May-31-1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Telegraph Operator	P.R.R.	Baltimore - Md.	U.S.A.

13. FATHER'S NAME: Williams ENGEL

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Alice V. Engel	42 S. Fulton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
John R. Travers M.D.		1/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 22-49	Lowndes Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huntington Williams, M.D.	C. P. Wippert & Son	1300 Eutaw St

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

G70783 ✓ 162 G70783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print): Henry A Seipp

2. DATE OF DEATH: Jan 17 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 323 S Calhoun St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore city
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 323 S. Calhoun St. 1903

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	9-18-1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Md. Dry Dock	Carroll County Md	U.S.A.

13. FATHER'S NAME: Henry Seipp

14. MOTHER'S MAIDEN NAME: Cornelia Boettinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-01-6999

17. INFORMANT: Mary E. Seipp ADDRESS: 323 S. Calhoun St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Lung with Metastasis (Squamous cell C.A.)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Months (?)

19A. DATE OF OPERATION: Jan 5, 1949

19B. MAJOR FINDINGS OF OPERATION: Biopsy of Cervical Gland showed Squamous Cell C.A.

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1948 to Jan 17, 1949 that I last saw the deceased alive on Jan 17, 1949 and that death occurred at 6:25 p. m., from the causes and on the date stated above.

23A. SIGNATURE: Abram Goldman, M. D.

23B. ADDRESS: 206 S. Gilmor St.

23C. DATE SIGNED: Jan 20 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 20-49

24C. NAME OF CEMETERY OR CREMATORY: Western

24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR: F. B. Gilbert & Son ADDRESS: 300 Eutaw St

VS 150

Funeting from Williams, Md

473

7

G70784 ✓ G70784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

007 Registered No.

BIRTH NO. B.C.H-21435

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. correct age is especially important.

1. NAME OF DECEASED (Type or Print): Robert Glover

2. DATE OF DEATH: 1/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1005 N. Arlington 16-1

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: March, 1945
9. AGE (In years last birthday): 3 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Glover
14. MOTHER'S MAIDEN NAME: Ethel Hunter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ethel Glover ADDRESS: 1005 N. Arlington Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Malnutrition.
(B) Pulmonary tuberculosis.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George A. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1/20/1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/24/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949
REGISTRAR: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams ADDRESS: 312 Lehmondale St

VS 151

13B

G70785 ✓ 420.1 H43 G70785

BIRTH NO. G70785

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) JOHN HENRY ANNEN

2. DATE OF DEATH 1-20-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore 54 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2952 Guilford Ave. 12 07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	W	MAY 13 1889	59 yrs	8 7	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank Louis Annen
14. MOTHER'S MAIDEN NAME Ella Moffett
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 216-09-4943
17. INFORMANT History ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral embolus — DUE TO
(B) Coronary artery disease — DUE TO
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertension, Cardiovascular disease

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-19 19 49 *to* 1-20 19 49 *that I last saw the deceased alive on* 1-19 19 49 *and that death occurred at* 2 25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Francis J. Catlin M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 1-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE JAN 22 1949
24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER
24D. LOCATION (City, town, or county) (State) 4430 BELAIR RD MD

DATE RECEIVED BY LOCAL REGISTRAR JAN 21 1949
REGISTRAR'S SIGNATURE Entering for Williams, M.D.
25. FUNERAL DIRECTOR Diffil Bros. ADDRESS 1800 E LOMBARD ST

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physician: please write the cause of death clearly and legibly.

93 D

B.C. 48-25674 Medical Examiners Case G70786

CERTIFICATE CORRECTED ~~CERTIFICATE CORRECTED~~ G70786

BIRTH NO.

CERTIFICATE OF DEATH 213

Registered No.

1. NAME OF DECEASED (Type or Print): Sharon Hauser

2. DATE OF DEATH: Jan 20 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2552 Asgwith St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2552 Asgwith St

c. Length of stay in Baltimore: Years 2 Mos. Days 9-7

6. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Single	Nov 25-48		2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Carroll Hauser

14. MOTHER'S MAIDEN NAME Evelyn Feit

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Carroll Hauser ADDRESS 2552 Asgwith St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure

DUE TO

(B) Pulmonary Congestion

DUE TO

(C) Enlarged Thymus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY

Earl Penn

Earl Wm. C. Helfrich M.D.

CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-20 , 1949, *to* , 19 , *that I last saw the deceased alive on* Dec , 19 , *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE David Josephson M.D.

23B. ADDRESS Sinai Hosp

23C. DATE SIGNED Jan 21 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1-21-49

24C. NAME OF CEMETERY OR CREMATORY Hebrew Mt Carmel

24D. LOCATION (City, town, or county) Balto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 21 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR Jack Lewis

ADDRESS 2100 Eutaw Pl

VS 150

64

✓ X 670787

670787 BALTIMORE CITY HEALTH DEPARTMENT 450.1 / 472.1 Registered No.

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Barabara Hoefel

2. DATE OF DEATH January 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 141 W Meadow Road.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last Birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	W	11-1-1868	80	2	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME —

14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO

17. INFORMANT Family - Same ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gangrene left foot

DUE TO

(B) Generalized Arteriosclerosis Cardiac

DUE TO Vascular Disease

(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Renal Insufficiency

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-14, 1949 *to* 1-20, 1949 *that I last saw the deceased alive on* 1-20, 1949 *and that death occurred at* 2:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE John Oughtaver M. D.

23B. ADDRESS University Hospital

23C. DATE SIGNED 1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify) B.

24B. DATE 1-24-49

24C. NAME OF CEMETERY OR CREMATORY Cedar Hill

24D. LOCATION (City, town, or county) (State) Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 21 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR James L. McCauley ADDRESS 13c k. Fort Ave.

931

VS 150

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70788 ✓ 422.1 G70788

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Rosaria Sanzone

2. DATE OF DEATH: January 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5621 Carter Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 5621 Carter Ave
B. COUNTY 27 - 44
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Oct. 6 1870	78	3	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Cefalu Italy	

13. FATHER'S NAME: Francesco Sanzone

14. MOTHER'S MAIDEN NAME: Concetta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no	no	no

17. INFORMANT: Vincent Sanzone — ADDRESS: 5621 Carter Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 1946 *to* 1/19, 1949 *that I last saw the deceased alive on* 1/19, 1949, *and that death occurred at* 4 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. J. Battaglia M. D.	5829 Belair Rd	1/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	January 23/49	Holy Redeemer Cemetery	Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 21 1949	Huntington Williams, M.D.	Frank Della Vale — 322 S. High St.

VS 150

939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

670783 ✓ 160 670789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Genoeffo Pierorazio

2. DATE OF DEATH Jan. 20 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1822 Aliceanna St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 1822 Aliceanna St. B. COUNTY 2 - E
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
male	white	married	July 15 1876	72	6 / 20	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter Helper	Carnegie Ill. Steel Co.	Palena Italy	U.S.A.

13. FATHER'S NAME Antonino Pierorazio

14. MOTHER'S MAIDEN NAME Angiolina Papa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no	172-07-0991	Antonino Pierorazio	1822 Aliceanna St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Adenocarcinoma of Parotid	6 mos
DUE TO		
(B)	Epithelioma of Nose	15 yrs
DUE TO		
(C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1 - 16 , 1949, *to* 1 - 20 - , 1949, *that I last saw the deceased alive on* 1 - 19 - , 1949, *and that death occurred at* 5.30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John. Costantini, M. D.	234 S. Conkling Street	1-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 23 1949	Holy Redeemer	Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	[redacted] Washington Williams, M.D.	Frank Della Rocca	322 S High St.

VS 150

53

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

G70790 ✓ 4221 G70790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): (MAURICE MOLLACK) MORRIS MOLLACK

2. DATE OF DEATH: January 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 310 S. Freemont Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	Colored	Divorced	unknown	59 Yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sailor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cambridge Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Richard Mollock
14. MOTHER'S MAIDEN NAME: Ellen -
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO. 217-27-6694
17. INFORMANT: Della Brown ADDRESS 528 W Lee St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiac -
DUE TO
(B) Vascular Disease
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Emily Kemp M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 1-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: 1-24-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemty
24D. LOCATION (City, town, or county) (State): Balto.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Walter B. Sprague ADDRESS: 1319 W. Hamby St.

939

VS 151

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70791 ✓ 15-7 G70791

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. G70791 Registered No.

1. NAME OF DECEASED (Type or Print) ALBERT R. LANDON
2. DATE OF DEATH JAN 21st 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2241 W. LEXINGTON ST
c. Length of stay in Baltimore 48 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2241 W. LEXINGTON ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	12/17/1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PIPE FITTER	Government	Maryland	U. S. A.

13. FATHER'S NAME Samuel H. Landon
14. MOTHER'S MAIDEN NAME Carrie Richards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
WWI	✓	Mrs Mary M. Landon 2241 W. LEXINGTON ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Gastric hemorrhage	1 day
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)	Carcinoma of the head of the pancreas -	1 year.
(C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 1948	Carcinoma of head of pancreas	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from 4/6/48 19__, to 1-20-49, 19__, that I last saw the deceased alive on 1-20-49, 19__, and that death occurred at 6:20 a. m., from the causes and on the date stated above.

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
AC Cole -	4 N. Fulton ave	1/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/24/49	Baltimore National	5501 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 21 1949	Huntington Williams, M.D.	John J. Cowan & Son 901 Hollins St

46g

Correct age if especially important. Physician: please write the cause of death clearly and legibly.

G70792

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.1 G70792 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 Monroe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 16-04
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Monroe St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frances S. Truett

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 16, 1872

8. AGE: Years	Months	Days	If less than one day
76	9	5	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name George Hartman
13. Birthplace Md.

MOTHER
14. Maiden Name Cordelia Garrison
15. Birthplace Md.

16 (a) Informant Samuel Truett
(b) Address 1130 N Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-49 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elgey O. Wilson
(b) Address 1010 Brantley Ave

JAN 21 1949 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1949, at 5 25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1949 to Jan 21 1949 and that I last saw her alive on Jan 17 1949.

Immediate cause of death Cardio Vascular Disease — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. William Frey M. D.
Address 1708 Penna Ave Date signed 1/21/49

VS 180

93D

G70793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

442 G70793 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sarah Booze

2. DATE OF DEATH Jan 18 1949

3. PLACE OF DEATH A. Baltimore City, Maryland Sarah Baltimore 1317

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1317 Madison Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1317 Madison Ave. 11-04

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col.	Widowed	Jan. 28. 1882	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Motgomery Co Md.	U.S.A.

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Elroy O. Wilson 1000 Brantly ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia, Cardeo — DUE TO — 2 days

(B) Vascular Renal Disease — DUE TO — 3 mos

(C) Arteriosclerosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/5, 19 49 *to* 1/18, 19 49 *that I last saw the deceased alive on* 1/18, 19 49 *and that death occurred at* 4:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Lackman M. D.	600 N. Arlington Ave.	1/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 24. 1949	Arbutus Mem. Park Cem	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR A. ADDRESS
JAN 21 1949	Evelyn Williams, Mgr	Elroy O. Wilson 1000 Brantly Ave.

VS 150

131a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G70794 ✓ +20.0 G70794

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. L 4747

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William James Yorkman
2. DATE OF DEATH: Jan. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 509 N. Ann St.
c. Length of stay in Baltimore: 87 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 409 Ann Street 1-04

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C.	W	6-19-61	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore Md	U.S.A.

13. FATHER'S NAME: George ? Yorkman
14. MOTHER'S MAIDEN NAME: ? Hannah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	Gladys Yorkman	409 N Ann St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days.
DUE TO
(B) Arterio-Sclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
-		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
-		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-17, 1948 *to* 1-19, 1949 *that I last saw the deceased alive on* 1-19, 1949 *and that death occurred at* 5:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R B Leighton M. D.	501 Cherry Hill Road	1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	1-26-49	Mt Calvary Cem.	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams, M.D.	Elroy O. Wilson	1005 Brantley ave

VS 150

937

correct age is especially important. Physician: please write the cause of death clearly and legibly.

Oak 670795 ✓ 420.0 670795

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sarah Westcott

2. DATE OF DEATH: JAN 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 81 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1419 E. Fairmount Ave

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 2.8.67
9. AGE (In years last birthday): 81 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): O.O.P.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: ? ?
14. MOTHER'S MAIDEN NAME: ? ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 5-7 days
DUE TO
(B) Arteriosclerotic Heart Disease — several years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Marked Hypochromia — many years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1.16. 1949 to 1.19 1949 that I last saw the deceased alive on 1.19 1949 and that death occurred at 330 a.m., from the causes and on the date stated above.

23A. SIGNATURE: Bertram E. Sprague M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 24-49
24C. CEMETERY OR CREMATORY: ~~Baltimore~~ Greenwood Cem. Nat. Prog.
24D. LOCATION (City, town, or county) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1000 Brunty Ave

VS 150

937

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G70796

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1949

G70796

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): EDWARD L. WARD

2. DATE OF DEATH: Jan. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4410 Greenway

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4410 Greenway

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
male	white	married	Aug. 26, 1876	72 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
lawyer		A. A. County	

13. FATHER'S NAME: Joseph Ward

14. MOTHER'S MAIDEN NAME: Mary Jane Wells

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	214-26-2817	Mrs. Mary Saunders Ward	4410 Greenway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Cervical glands — INTERVAL BETWEEN ONSET AND DEATH: about July 1947

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Dec 1947	Biopsy of Cervical gland	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1947, *to* Jan 20, 1949, *that I last saw the deceased alive* Jan 19, 1949, *and that death occurred at* 8.15 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	705 Medical Arts	1-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1/22/49	Hollywood Cem.	Richmond, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 21 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

55E

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

✓ 422.1

G70797 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70797

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma E. Starkey

2. DATE OF DEATH: Jan. 18th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1708 Darley Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1708 Darley Ave. 8-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widow	July 17th 1879	69	6	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Isma J. Smart

14. MOTHER'S MAIDEN NAME: Kellmond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO:

17. INFORMANT: Lucy Starkey - 1708 Darley Ave. ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic cardio-vascular disease	10 yrs
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Diabetes Mellitus	12 yrs

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 1/18, 1949, *that I last saw the deceased alive on* 1/18, 1949, *and that death occurred at* 11:40 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Helen V. Magennis M. D.

23B. ADDRESS: 1445 N Gay St

23C. DATE SIGNED: 1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/22/49

24C. NAME OF CEMETERY OR CREMATORY: Moreland Memorial Park

24D. LOCATION (City, town, or county) (State): Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: C. J. Fanning & Son - 1938 E. Lafayette ADDRESS ave.

VS 150

61

correct age is especially important. Physician: please write the cause of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

422.1 G70798 Registered No.

BIRTH NO. G70798

1. NAME OF DECEASED (Type or Print): Kate Smit

2. DATE OF DEATH: 1/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3150 Leeds St
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 3150 Leeds St 20-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	Jan. 1, 1872	77	- 19	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper	Home	Balto. County, Md.	U.S.A

13. FATHER'S NAME: Onis Smit

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	None	Mike Kamp	3150 Leeds St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arterio sclerotic C.V disease	
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
P. J. Trubrinke M.D.		1/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-22-49	Western Cemetery	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 21 1949	Huntington Williams, M.D.	George L. Schwab 2101 Frederick Ave.

VS 151

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G70799 51 - 15756 CERTIFICATE CORRECTED 5-26-50 G70799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Reinhardt Glassner**

2. DATE OF DEATH **Jan. 21, 1949**

3. PLACE OF DEATH: A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Baltimore City Hospital 4940 Eastern Ave.**

c. Length of stay in Baltimore **15 yrs.** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **109 Aisquith St.** 5-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	Widowed	May 17, 1863	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Germany	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ferdinand	Bertha ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 2 d.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ASCVD — DUE TO

(C) Emphysema

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-20-49 *to* 1-21-49, 19__, *that I last saw the deceased alive on* 1-20-49, 19__, *and that death occurred at* 2 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. J. Nilson, M.D.	Bishop.	1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/24/49	Mt. Carmel Cemetery	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 22 1949	Terminus for Williams, M.D.	H. Sonder & Sons 1649 E. Fayette Ave.

VS 150

939

70800 ✓ 331 G70800

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) CHARLES GUTERMUTH

2. DATE OF DEATH Jan. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5702 White Avenue

c. Length of stay in Baltimore 77yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5702 White Avenue

5. SEX Male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 4, 1870
9. AGE (In years last birthday) 78 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Harness maker- retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George F. Gutermuth
14. MOTHER'S MAIDEN NAME Eva E. Berkes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-07-5519
17. INFORMANT Miss Bertha Gutermuth ADDRESS 5702 White Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1948 *to* 1/19, 1949 *that I last saw the deceased alive on* 1/19, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE D. T. Baxter Laughlin M. D.
23B. ADDRESS 5829 Belair Rd
23C. DATE SIGNED 1/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/24/49
24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 22 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. ADDRESS NORTH AVE & BROADWAY 83a

VS 150

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70801

BALTIMORE CITY HEALTH DEPARTMENT 002 G70801

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elise J Gotsch (ELISE JULIA GOTSCH)

2. DATE OF DEATH Jan 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

C. Length of stay in Baltimore 35 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2900 Shirey Avenue 2203

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	Jan. 4, 1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Germany	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frederick T. Gotsch	Marie W. Gehring

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	212-01-6010	Miss Rose R. Gotsch-2900 Shirey Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) Bronchiectasis — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO

(b) Pulmonary Fibrosis — 5 years.

DUE TO

(c) Pulmonary Tuberculosis (old) — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 3, 1949 *to* Jan 19, 1949, *that I last saw the deceased alive on* Jan 19, 1949 *and that death occurred at* 12:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Betty May Young M. D.	Maryland General Hospital	1/19/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/22/49	St. Matthews Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 22 1949	Huntington for Williams, M.D.	HENRY SANDER & SONS, INC.

VS 150

BALTIMORE, MARYLAND 13B

Physician: please write the cause of death clearly and correct age is especially important.

G/0802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G/0802

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GOLDIE HARTMAN

2. DATE OF DEATH: JAN 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore DUNDALK
D. STREET ADDRESS (If rural, give location): 1808 Belle Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Aug 22, 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Hartlove	Elizabeth Engle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Hospital records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CHRONIC MYOCARDIAL DEGENERATION

DUE TO HEART BLOCK

AURICULAR FIBRILLATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic heart failure, Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF ORERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 25, 1948, *to* Jan 20, 1949 *that I last saw the deceased alive on* Jan 20, 1949, *and that death occurred at* 9:50 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John R. Shell M. D.	Mercy Hospital	1/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 24/49	Mt Carmel	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
JAN 22 1949	Huntington Williams, M.D.	Uhl Funeral Home	2008 Orleans

VS 150

93D

correct age is especially important. Physician: please write the cause of death clearly and legibly.

463 G70803

G70803

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): LILLIE HOLTHAUS

2. DATE OF DEATH: Jan. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1102 E. 36th St.,
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1102 E. 36th St., 9-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Nov. 14, 1870	78	2	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home		Virginia	

13. FATHER'S NAME: Godfrey Otto

14. MOTHER'S MAIDEN NAME: Margaret Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.			Mrs. Harry W. Grambrill	1102 E. 36th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia due to
DUE TO Hardening of arteries
(B) Physicis of Leg
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Nov 16, 1948 *to* Jan 21, 1949 *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. A. C. Hearn M. D.	720 Garrison Blvd	1/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 24, 1949	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams, M.D.	Ulrich Funeral Home	2008 Orleans. St.

VS 150

97

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Exact age is especially important.

670804 ✓ 742 670804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry C. Gessner
2. DATE OF DEATH: Jan 22 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 4741 Elbamboake
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Baltimore B. COUNTY Md.
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
c. Length of stay in Baltimore Balto. Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location) 4741 Elbamboake 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married.	Aug 22 1885	63 65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Iron Worker Helper.	Foreman	Baltimore Md.	Yes

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Gessman	Elizabeth Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—		Martha Gessner	4741 Elbamboake

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Renal disease. — INTERVAL BETWEEN ONSET AND DEATH: 2 YRS.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. , 1947, to Jan. 21 , 1949, that I last saw the deceased alive on Jan 20 1949, and that death occurred at 12:15 Pm., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lloyd E. Taylor M. D.	3902 Greenmount Ave.	Jan. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 24 1949	Holy Redeemer Cem.	Belair Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 22 1949	Turning for Williams, M.D.	John C. Rosan	3000 E. Baltimore St.

VS 150

1312

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70805 ✓ 442 G70805

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Crozier Sarah C. Rigby

2. DATE OF DEATH Jan. 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2568 McCulloh St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2568 McCulloh St. 12 C 3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	Colored	Widow	July 2, 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Chestertown, Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Oscar James Crozier	Mary E. Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Esther Roberts	2568 McCulloh St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) hypertensive cardio-renal disease	2 yrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	diabetes mellitus	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. [illegible] M. D.	1500 E. Madison St	1-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 24, 1949	Janes Cem.	Chestertown, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 22 1949	Huntington Williams, M.D.	Mrs. Frances A. Hemsley	578 W. Biddle St.

VS 150

61

Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G70806 ✓ 610 G70806

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) LEE L. LOWMAN (LEE L. LOWMAN.)

2. DATE OF DEATH 1/21/49.

3. PLACE OF DEATH: A. Baltimore City, Maryland SINAI HOSP

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital.

C. Length of stay in Baltimore 67 Yrs. More Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5720 Oakshire Road. 27-15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	2/7/1881.	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Broker	Mortgage.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME Simon Lowman

14. MOTHER'S MAIDEN NAME Rosa Lauer.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		219-16-3084	Mrs. Adelaide B. Lowman,	5720 Oakshire Road.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritonitis

DUE TO

(B) Rupture of a Ureters

DUE TO

(C) Supra Pubic Prostatectomy performed 1/11/49

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/11/49	Prostatic Hypertrophy	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/6, 1949, *to* 1/20, 1949, *that I last saw the deceased alive on* 1/20, 1949, *and that death occurred at* 1:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benson Schwartz M. D.	Sinai Hospital	1/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/23/49.	Har Sinai Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 22 1949	Hunting for Williams, Mgr.	Abel Sonneborn & Sons	1902 Eutaw Place.

VS 150

137a

Correct age is especially important. Physician: please write the cause of death clearly and forcibly.

G70807 — BALTIMORE CITY HEALTH DEPARTMENT — 410 — G70807

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES W. BUSICK

2. DATE OF DEATH: Jan. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1611 N. Broadway
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1611 N. Broadway — 8 — 0 6

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Jan. 4, 1863
9. AGE (In years last birthday): 86 yrs. — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Joshiah Busick
14. MOTHER'S MAIDEN NAME: Katie Boyer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT — ADDRESS: Mrs. E. V. Stein - 1611 N. Broadway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Mitral Stenosis	2 yrs
DUE TO (B)	Arterio Sclerosis	10 yrs
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1948, *to* Jan-20, 1949, *that I last saw the deceased alive on* Jan 19-, 1949, *and that death occurred at* 2 4 m., *from the causes and on the date stated above.*

23A. SIGNATURE: E Gill Hall M D M. D.
23B. ADDRESS: 1021 E North Ave
23C. DATE SIGNED: Jan 21-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/24/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: WM. J. TICKNER & SONS — Balto., Md.

VS 150

920

G70808

Dr. Milton Kress
Medical Arts Bldg.

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70808

1. NAME OF DECEASED (Type or Print): Marie Estelle Miller

2. DATE OF DEATH: Jan. 21st, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harford Convalescent Home 4700 Harford Road
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2111 N. Calvert Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	divorced	June 13, 1901	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10B. KIND OF BUSINESS OR INDUSTRY: Town Restaurant
11. BIRTHPLACE (State or foreign country): Millersburg, Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ~~Unknown~~ Richard F. Adams
14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Sarah Shaffner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-14-4196
17. INFORMANT: Mrs. Arthur Lambert, ADDRESS: 7403 Glenoak

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Cervix (Hemorrhage from tumor)
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 15 mo.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1, 1948, *to* Jan 21, 1949, *that I last saw the deceased alive on* Jan 20, 1949 *and that death occurred at* 12:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Milton B. Kress M. D.
23B. ADDRESS: medical arts Bldg
23C. DATE SIGNED: 1/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-24-49	Oak Hill Cem.	Millersburg, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR, ADDRESS: Leonard J. Ruck, 5305 Harford Road.

VS 150

48a

Correct age is especially important. Physician: please write the cause of death clearly and fully.

G70809 ✓ 331 G70809

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) ELIZABETH PAGANO

2. DATE OF DEATH 1/19/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 504 Poplar Grove st.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 59 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY ---------
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 504 Poplar Grove St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	white	widowed	Apr. 4, 1875	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home	----	Chester Penna.	U.S.A.

13. FATHER'S NAME: John J. Eaton

14. MOTHER'S MAIDEN NAME: Elizabeth---------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	none	John Pagano	504 Poplar Grove st.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. , 1947 to 1/19 , 1949 *that I last saw the deceased alive on* 1/19/ , 1949 *and that death occurred at* 2 P.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. J. Battaglia M. D.	5829 Belair Rd	1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 24/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 22 1949	Huntington Williams, M.D.	Chas. J. Evans' Son, Inc.	118 N. Mt. Royal Ave 83a

VS 150

Complete all items. Important: Physician: please write the cause of death clearly and legibly.

Medical Examiner's Case ✓

G70810 — BALTIMORE CITY HEALTH DEPARTMENT — G70810

CERTIFICATE OF DEATH

BIRTH NO. — Registered No. 157

1. NAME OF DECEASED (Type or Print): HINTON, MINNIE
2. DATE OF DEATH: 1-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PROV. DEAF HOSPITAL
C. Length of stay in Baltimore: 30 YEARS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 408 N. BOND ST 6-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
FEMALE	COLORED	WIDOWED	July 8 1897	51				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		VIRGINIA	

13. FATHER'S NAME: EFFUS WILSON
14. MOTHER'S MAIDEN NAME: ANNIE WRIGHT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		HOSP. TAR CHART.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	① Generalized Carcinomatosis: Metastases to Peritoneum; Serosal surfaces of abdominal, thoracic viscera, Spleen, Liver, - 1° Site not established.	—
DUE TO (B)	② Cerebral Edema	—
DUE TO (C)	③ Pulmonary Edema & Congestion (over)	

CERTIFICATION APPROVED BY

Earl Penny M.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 20, 1948 *to* Jan. 19, 1949, *that I last saw the deceased alive on* Jan 19, 1949 *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Simon D Ezey Carter, Jr. M. D.	Provident Hospital	1/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Jan. 25-49	Mt Calvary Cem.	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR. ADDRESS
JAN 22 1949	Huntington Williams, M.D.	Elroy D. Wilson, 1000 Brantly Ave

VS 150

469

collect age is especially important. Physician: please write the cause of death clearly and legibly.

XV 170

G70811

BIRTH NO. G70811

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPHINE SCHILLO

2. DATE OF DEATH: 1-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore — 4 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore #20
D. STREET ADDRESS (If rural, give location): 31-C Cedar drive Oak Brow Apt.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W	8-22-88	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Illinois	U.S.A.

13. FATHER'S NAME: Thomas Barrett

14. MOTHER'S MAIDEN NAME: Ellen McCoy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Thomas B. Schillo (Husband) ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of Breast	6 yrs
DUE TO	with metastases	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1943 9-27-48	Radical mastectomy - Ca breast Pulmonary Embolism	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-11-, 1948 to 1-21-, 1949 *that I last saw the deceased alive on* 1-21-, 1949, *and that death occurred at* 4:50 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allyn F. Judd M. D.	Mercy Hospital	1-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 25/49	Calvary Cemetery Chicago, Ill.	Chicago, Ill

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 22 1949	Thurlington Williams, M.D.	P. J. Meany Son	645 N. Eutaw St.

VS 150

50

Physician: please write the cause of death clearly and legibly. Exact age is especially important.

✓ 366

G708 12 — BALTIMORE CITY HEALTH DEPARTMENT — G708 12

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charlotte Summerville

2. DATE OF DEATH: Jan. 18-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 411 N. Dunbar St

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 411 N. Dunbar St 6-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Widow	Nov. 10-1879	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Cambridge Md.	✓

13. FATHER'S NAME: Albert Harris

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Laura Summerville — ADDRESS: 411 Dunbar

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 wks

DUE TO

(B) Exposure and Senility — Infl

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify, that I attended the deceased from* 12-1-48, to 1-18-49, *that I last saw the deceased alive on* 1-18-49, *and that death occurred at* 1:15 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jas. R. Blake M. D.	1603 N. Caroline	1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-22-49	Mt. Calvary	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 22 1949	Huntington Williams, M.D.	Byron T. Mamie Wright	721 Aisquith

VS 150

107

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G708 Pkg 3 ✓ X 163 G70813

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): George H. Plessner

2. DATE OF DEATH: JAN 21 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Fla
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Conte Vedra Beach
D. STREET ADDRESS (If rural, give location): 140 Duvall Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	4-15-03	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Diversion Manager
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Theodore Plessner
14. MOTHER'S MAIDEN NAME: Bernadine Muller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) circulatory collapse — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) bronchiogenic carcinoma — 5 mo.

DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-20 1948, to 1-21, 1949, *that I last saw the deceased alive on* 1-21, 1949, *and that death occurred at* 955 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. W. Smith, M.D. M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: 1-22-49
24C. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN
24D. LOCATION (City, town, or county) (State): PLEASANTVILLE, N.Y.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 22 1949
REGISTRAR'S SIGNATURE: Permission for Removal, Md.
25. FUNERAL DIRECTOR: WM J. TICKNER & SONS ADDRESS: BALTO. MD.

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47c

G70814 ✓ 794 G70814

BIRTH NO. G70814

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Margaret E. Owens

2. DATE OF DEATH: Jan. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 509 Edgewood St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 80 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 509 Edgewood St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Married	June 6, 1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Catonsville, Md.	U.S.A

13. FATHER'S NAME: Frederick Maisel

14. MOTHER'S MAIDEN NAME: Margaret E. Ruff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	No	None	Mr. Norman Owens	2447 Lauretta Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility — INTERVAL BETWEEN ONSET AND DEATH: Several years.

DUE TO

(B) Cardiac Failure.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 17, 1949, *to* Jan 20, 1949, *that I last saw the deceased alive on* Jan 19, 1949, *and that death occurred at* 5-10 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George E. Shannon M.D. M. D.	820 Medical & Sc Building	Jan 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	1/24/49	Salem Luthern	Catonsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 23 1949	Pennington Williams, M.D.	John T. Stansbury	2700 Edmondson Ave

VS 150

1626

G70815 G70815

BALTIMORE CITY HEALTH DEPARTMENT 420.1

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ANNA P. HERR

2. DATE OF DEATH: Jan. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3704 Duvall Ave.
c. Length of stay in Baltimore: 2 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3704 Duvall Ave. 15-38

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: May 26, 1880
9. AGE (In years last birthday): 68 yrs. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): York, Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward T. Lewis
14. MOTHER'S MAIDEN NAME: Catherine Ilgenfritz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mr. Ben G. Herr ADDRESS: 3704 Duvall Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
ANTECEDENT CAUSES
(B) none.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 14, 1949 *to* June 21, 1949, *that I last saw the deceased alive on* June 20, 1949 *and that death occurred at* 11.45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ben Edwell M. D.
23B. ADDRESS: 4100 Edmondson Ave.
23C. DATE SIGNED: 1/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/25/49
24C. NAME OF CEMETERY OR CREMATORY: Prospect Hill
24D. LOCATION (City, town, or county) (State): York, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 23 1949
REGISTRAR'S SIGNATURE: Pennington Robinson M.D.
25. FUNERAL DIRECTOR: WILLIAM J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

94a

G70816 BALTIMORE CITY HEALTH DEPARTMENT 260 G70816
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): STELLA BENESCH.
2. DATE OF DEATH: 1/22/49. 1/22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3404 Fallstaff Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 6 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3404 Fallstaff Road. 2-7-20

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Widow	4/3/1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Milwaukee, Wis.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Solomon Winter
14. MOTHER'S MAIDEN NAME: Louise Freudenfeld

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. H. E. Levin, ADDRESS: 3400 Hilton Road.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chr. card. vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 20 years
DUE TO
(B) auricular fibrillation
DUE TO
(C) Diabetes Mellitus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-1 1941, to 1-22, 1949, that I last saw the deceased alive on 1-21, 1949, and that death occurred at 7 P. m., from the causes and on the date stated above.

23A. SIGNATURE: H Edmund Levin M. D. | 23B. ADDRESS: 3400 Hilton Rd | 23C. DATE SIGNED: 1/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1/23/49.	Spring Hill Cem.	Milwaukee, Wisconsin.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harris Sonnenborn & Son ADDRESS: 1902 Eutaw Place.

61

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ZIPPIE WEIS (ZIPPI WEIS.) 2. DATE OF DEATH 1/22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland WEST BALTO. GEN. HOSP.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTIMORE GENERAL HOSPITAL
c. Length of stay in Baltimore 77 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) Esplanade Apartments. 13-01

5. SEX F Female | 6. COLOR OR RACE W White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH 8/10/1871. | 9. AGE (In years last birthday) 77 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jacob Goldstone
14. MOTHER'S MAIDEN NAME Katherine DeHann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Mr. LeRoy Weis ADDRESS 2321 N. Longwood St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/22/ 1949 *to* 1/22/1949 *that I last saw the deceased alive on* 1/22/ 1949 *and that death occurred at* 6:55P *m., from the causes and on the date stated above.*

23A. SIGNATURE Leonard H. Goldenberg M. D. | 23B. ADDRESS West Balto Gen Hosp. | 23C. DATE SIGNED 1/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1/24/49. | 24C. NAME OF CEMETERY OR CREMATORY Hebrew Friendship | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 26 1949 | REGISTRAR'S SIGNATURE Huntington Williams, Mo | 25. FUNERAL DIRECTOR Harrod Sonnenborn & Son. ADDRESS 1902 Eutaw Place.

937

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G70818

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Max Addiſ — MAX Addis

2. DATE OF DEATH: January 23, 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mount Nursing Home

D. STREET ADDRESS (If rural, give location): 1509 N Bentalou St 15 03

c. Length of stay in Baltimore: 45 yrs (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. last birthday)	If under 1 Year: Months Days	If under 24 hours: Hours Min.
Male	White	Married	1874	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Gerson Addif

14. MOTHER'S MAIDEN NAME: Miriam ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mrs Jean Vein 3767 Columbus Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Renal Disease

DUE TO

(B) Arteriosclerosis Generalized Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: (A) years; (B) years; (C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None done

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1975, *to* January 23, 1949, *that I last saw the deceased alive on* 1-22, 1949, *and that death occurred at* 1:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sol Levinson M. D.

23B. ADDRESS: 120 Poplar Grove St

23C. DATE SIGNED: 1-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 23, 1949

24C. NAME OF CEMETERY OR CREMATORY: Hebrew Young Men Cem

24D. LOCATION (City, town, or county) (State): Windsor Mill Road

DATE RECEIVED BY LOCAL REGISTRAR: JAN 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams

25. FUNERAL DIRECTOR — ADDRESS: Sol Levinson & Bro 1126 W Northern

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131a

Correct age is especially important. Physician please write the cause of death clearly and legibly.

G70819

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.1 G70819

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Francis Joseph Bibleheiser

2. DATE OF DEATH: 1/21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1617 Eutaw Place

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 14-01
D. STREET ADDRESS (If rural, give location): 1617 Eutaw Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W			23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Real estate		Balto. Md	U. S. A.

13. FATHER'S NAME: Francis J. Bibleheiser

14. MOTHER'S MAIDEN NAME: Ellen Morrow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Sarah H. Bibleheiser

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anteroseptic C.V. disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
P. L. Sulinski M.D.		1/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	1-25-49	Mount Cathedral	Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR, ADDRESS
JAN 23 1949		John D. Mitchell & Sons. 1908 Eutaw Place

938

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G70820

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1 G70820

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harriett W. Wrightson

2. DATE OF DEATH: Jan. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 701 E. Arlington Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

C. Length of stay in Baltimore: 24 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 701 E. Arlington Ave., Govans 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Dec. 16, 1864	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Talbott County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas Lowe

14. MOTHER'S MAIDEN NAME: Anna Pindell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. Harriett W. Mumford, 1715 Takoma Rd. ADDRESS: Towson, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 days.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary arterio-sclerosis

DUE TO

(C) None.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None.

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/23, 1949 *to* 1/20, 1949 *that I last saw the deceased alive on* 1/20, 1949 *and that death occurred at* 11.45 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE: J. Willis Gayton M. D.

23B. ADDRESS: 3963 Greenmount Ave.

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 1/24/49

24C. NAME OF CEMETERY OR CREMATORY: Olivet

24D. LOCATION (City, town, or county) (State): St. Michael's, Md.

DATE RECEIVED BY LOCAL REGISTRAR:

REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Pl.

VS 150

Returning for Additional Info

Ashton B. Mitchell

JAN 23 1949

Dr. Gayton 94a

H20.1 H93

G70821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70821 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): REBECCA COOPER

2. DATE OF DEATH: 1-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2505 Oswego ave
c. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2505 Oswego ave 13

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 85 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Benjamin Cooper ADDRESS 2505 Oswego ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
(B) Pneumonia — 10 yrs 2 wks.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 13, 1949 *to* Jan 21, 1949 *that I last saw the deceased alive on* Jan 21, 1949, *and that death occurred at* 9P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Reuben Kahan M. D.
23B. ADDRESS: 3700 Park Heights
23C. DATE SIGNED: Jan 23 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-23-49
24C. NAME OF CEMETERY OR CREMATORY: Adas Israel
24D. LOCATION (City, town or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 23 1949
REGISTRAR'S SIGNATURE: Emerson Williams, M.D.
25. FUNERAL DIRECTOR: Jack Levin Inc
ADDRESS: 2100 Eastern Ave

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. FEDORE DEMESOK LEODER DENESOOK

Registered No.

1. NAME OF DECEASED (Type or Print): THEODORE DENSUK

2. DATE OF DEATH: January 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — SINAI HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 417 S. Durham St. #31 2-07

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Not Know
9. AGE (In years last birthday): 50 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russian
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? Densuk
14. MOTHER'S MAIDEN NAME: Not know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 217-05-3133
17. INFORMANT: Mrs Anna Densuk — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of urinary bladder (Uremia) — DUE TO
(B) — DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 mos. +

19A. DATE OF OPERATION: Fall of 1948
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Bladder
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August, 1948, *to* January 20, 1949, *that I last saw the deceased alive on* Jan 20, 1949, *and that death occurred at* 8:20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. Lerman, M. D.
23B. ADDRESS: SINAI HOSPITAL
23C. DATE SIGNED: JAN 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 24-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Trinity Russian
24D. LOCATION (City, town, or county) (State): Elkridge Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 23 1949
REGISTRAR'S SIGNATURE: Wallace A. Williams, M.D.
25. FUNERAL DIRECTOR: John A. Grabliauckas Sr. — ADDRESS: 520 423 S. Paca St.

VS 150

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

180 ✓ G70823

G70823

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Fred Shul or Feodosey Cshurek
2. DATE OF DEATH: Jan. 20, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1532 E. Pratt St 3-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	— 1887	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Russia	

13. FATHER'S NAME: Joe Shul
14. MOTHER'S MAIDEN NAME: Zakla?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—		Records -	JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 12 mos
DUE TO
(over)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 8 1948 *to* Jan 20, 1949 *that I last saw the deceased alive on* Jan 20, 1949 *and that death occurred at* 4 20 m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William E. Chase M. D.	JOHNS HOPKINS HOSPITAL	1/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 24-49	Holy Trinity Russian	Elkridge Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
JAN 23 1949	Huntington Williams, M.D.	John L. Gretkowski 52a	423 S. Paca St.

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G70824

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

353.3

G70824 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALBERT GOETZE

2. DATE OF DEATH January 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Jail

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1627 Durham Street 8-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	single		54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) World War I

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Suffocation

DUE TO

(B) Epilepsy

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Baltimore City Jail

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 801 Buren Street 10-3

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 1 18 49 ? a.m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Suffocation by bedclothes during epileptic seizure

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Carl L. Reyer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]

23C. DATE SIGNED January 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Jan 26

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY Govans Presbyterian

24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 23 1949

REGISTRAR'S SIGNATURE Investigator for Williams, M.D.

25. FUNERAL DIRECTOR Ellsworth Armacost

ADDRESS 182 a 3911 Liberty Heights Ave

VS 151

correct age is especially important. Physician please write the cause of death clearly and legibly.

G70835 BALTIMORE CITY HEALTH DEPARTMENT 5722 G70825

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Arnold McKay
2. DATE OF DEATH: Jan 22, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
   B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
   C. Length of stay in Baltimore: Yrs. 13 Mos. 06 Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Md.
   B. COUNTY:
   C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
   D. STREET ADDRESS (If rural, give location): 3503 Hickory Ave.
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: Jan 19 1910
9. AGE (In years last birthday): 39 (If Under 1 Year: Months: Days; If Under 24 Hours: Hours: Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car Repairman
10B. KIND OF BUSINESS OR INDUSTRY: Patapsco & Back Rivers R. R.
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John E. McKay
14. MOTHER'S MAIDEN NAME: Annie Meade
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
    (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: 212-07-3781
17. INFORMANT: Mary E. McKay ADDRESS: 3503 Hickory Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Ulcerative Colitis	3-4 weeks
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	(C) Pneumonia, Rt middle & lower lobe	Terminal

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-5 1949 *to* 1-22, 1949, *that I last saw the deceased alive on* 1-22 1949, *and that death occurred at* 11:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marvin D. Davis M. D.
23B. ADDRESS: W. Balto. Gen. Hosp.
23C. DATE SIGNED: 1-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/25/49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): Annapolis Blvd.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: Paul E. Ehrensperger Jr. ADDRESS: 3615-17 Chestnut Ave.

VS 150

120R

Please write the cause of death clearly and fully. Physician: Important: Please write the cause of death clearly and fully. Exact age is especially important.

G-708-26 ✓ X G-708-26

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 420.1

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): PAUL WALLACE WILSON

2. DATE OF DEATH: January 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S.F. & G. Building 26 S. Calvert Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: BALTO
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27 Valethorpe
D. STREET ADDRESS (If rural, give location): 5648 Carville Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Oct. 18, 1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Underwriter	Insurance	Delaware	

13. FATHER'S NAME: Wallace Wilson
14. MOTHER'S MAIDEN NAME: Lydia Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W.W.I	215 07 8646	Florence Wilson	5648 Carville Ave Valethorpe 27

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Obstruction of mouth of left coronary artery by arteriosclerosis of aorta.
(B)
(C) Myocardial infarction.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/24/49	Balto. Nath. Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Edward J. McNabb ADDRESS: Catonsville

VS 151

94a

Correct age is especially important. Physicians please write the cause of death clearly and legibly.

G 708.27 ✓ 144 G 708.27

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: US Marine Hospital, Baltimore, 11 Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) City of Baltimore
(c) City or town Baltimore 18-02
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERTS, ERNEST SAMSON

3 (b) If veteran, name war: W.W I
3 (c) Social Security Account No.: ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mary L. Roberts
6 (c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): August 2 1881
8. AGE: Years 67 | Months 5 | Days 21 | Less than one day: hr. min.
9. Birthplace: Chile South America (town, county, and state)
10. Usual Occupation: Retired Captain, USA
11. Industry or business

FATHER
12. Name: Joseph Roberts
13. Birthplace: England

MOTHER
14. Maiden Name: Emily ?
15. Birthplace: England

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-49 (month) (day) (year)
(c) Cemetery or crematory: Family Cemetery
Location: Hanover County, Virginia

18 (a) Funeral director: George L. Schwab
(b) Address: 2401 Pennsylvania Avenue

19 (a) JAN 24 1949 (Date rec'd by registrar) Clayton Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 January 1949 at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 January 1949 to 23 January 1949, and that I last saw h[illegible] alive on 23 January 1949.

Immediate cause of death: Squamous cell carcinoma
Due to: ? soft palate & pharynx
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Lewis Jr. MD. M. D.
Address US Marine Hosp. Baltimore, Md Date signed 1-23-49

45F

VS 150

670828 ✓422.1 670828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CLARENCE TAWZER

2. DATE OF DEATH: January 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 222 South Eden Street

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 222 South Eden Street 3-0 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white		June 22, 1883	65	6	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
WATCHMAN	Maritime Union	York, Penna	

13. FATHER'S NAME: GEORGE TAWZER

14. MOTHER'S MAIDEN NAME: ANNA SHIMP

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	217-05-6849	Mrs. Elizabeth Houch	222 S. Eden Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-

DUE TO

(B) Vascular Disease -

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L Rogg M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Jan. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/24/49	Greenmount	York Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams, M.D.	Tillman & Doll	217 E. Lexington St

VS 151

937

Please write age in especially important. Physician: please write the cause of death clearly and legibly.

G70829

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

521 G70829 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DENNIS WRIGHT

2. DATE OF DEATH JAN 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTIMORE GENERAL HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1726 MONROE ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		JAN. 3 1898	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
BRICK LAYER	SELF	MARYLAND	

13. FATHER'S NAME Louis B Wright

14. MOTHER'S MAIDEN NAME Mary Boylan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		579-05-3292	Mrs Mary Wright	1726 N Monroe

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) POST-OPERATIVE SHOCK — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) BRONCHO-PLEURAL FISTULA — 5 WEEKS

DUE TO

(C) LUNG ABSCESS — 2 YEARS

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROTIC C-V DISEASE

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
22 JAN 1949	BRONCHO-PLEURAL FISTULA	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* DEC. 7, 1948 *to* JAN. 23, 1949, *that I last saw the deceased alive on* JAN 23, 1949, *and that death occurred at* 9.22A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Duncan M. Chechet M. D.	WEST BALTO. GEN. HOSP.	JAN. 23 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	1/27/49.	London Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams, M.D.	Wilhelm Corl Inc	1217 E Fayette

VS 150

114 D

G70830 ✓X 170.0 G70830

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Baby girl Davis

2. DATE OF DEATH 1-22-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union memorial Hospital

c. Length of stay in Baltimore Yrs. Mos. Days 4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Towson
D. STREET ADDRESS (If rural, give location) 3126 Joppa Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White		1-19-49			4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Maryland	USA

13. FATHER'S NAME James H. Davis

14. MOTHER'S MAIDEN NAME Elsie Kugel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Erythroblastosis foetalis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(B) Rh incompatability
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 19, 1949, *to* Jan 22, 1949, *that I last saw the deceased alive on* Jan 22, 1949, *and that death occurred at* 1 45 *p m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert R. Milan M. D.	Union Memorial Hospital	Jan 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/24/49	London Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams M.D.	Milton Cox Inc	1217 E Fayette St

VS 150

161c

6708.31 ✓491

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6708.31

1. NAME OF DECEASED (Type or Print): GEO. WEISS

2. DATE OF DEATH: 22 Jan 49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Zone 31

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2212 E Fayette St 31

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md — COUNTY: Balt.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 31
D. STREET ADDRESS (If rural, give location): 2212 E Fayette St 31 6-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	12 Nov 1868	80 Yr	2 10	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Pensioner~~ unemployed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Franz Karl Weiss
14. MOTHER'S MAIDEN NAME: Kunigunda ——
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown): No
16. SOCIAL SECURITY NO.: 214-22-7713
17. INFORMANT: Mrs. Ga Dues — ADDRESS: 2212 E Fayette St 31

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia, bilateral, primary
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: 1 mo

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 17 Jan 49 *to* 22 Jan 49, *that I last saw the deceased alive on* 22 Jan, 19 49, *and that death occurred at* 7:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 2114 E Fayette St 31
23C. DATE SIGNED: 22 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/25/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, township or county) (State): Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilhelm & Son Inc — ADDRESS: 1218 Park Ave

VS 150

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G70832 ✓ 521 G70832

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Andrew F. Doelle

2. DATE OF DEATH: 1/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
c. Length of stay in Baltimore: 60 yrs 10 Mo (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 134 W. Randall
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 134 W. Randall St. (30) 73 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	March 21, 1888	60 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman	Bethlehem Steel Shipyard	Baltimore, Md.	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Doelle	Ida —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	214-16-6635	Mrs Sophia A Doelle	134 W Randall

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) lobar Pneumonia, Complete Rt lung — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

(C) Lung Abscess Rt. Base

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/20, 1949 *to* 1/21, 1949 *that I last saw the deceased alive on* 1/21/49, 19___, *and that death occurred at* 6:40 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Samuel P. Scalia M. D.	South Balto. General Hospital	1/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 24 1949	St Mathews	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Thurlington for Williams, M.D.	H. Funeral Home	1400 St Charles St.

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G70833 ✓163 G70833

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mr. Claude Kromling Downing

2. DATE OF DEATH: January 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5207 Eastern Avenue 26 05

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 24, 1897
9. AGE (In years last birthday): 51 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel Co.
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: Donald Downing — 5207 Eastern Ave.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of upper lobe of left lung
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Healed gastric ulcer — gastroenterostomy 6 mos.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/6/ , 1949, *to* 1/20/ , 1949, *that I last saw the deceased alive on* 1/20/ , 1949, *and that death occurred at* 4:00 AM, *from the causes and on the date stated above.*

23A. SIGNATURE: J. Joseph Krejci M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: 1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/24/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): 7225 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Clarence F. Hoffmann 1639 Broadway.

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G70834 ✓X 443 G70834

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Concetta Bettaglia

2. DATE OF DEATH: January 22 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 12 Bermuda Square

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W		11/9/1888	60	2 / 11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Italy	U.S.A.

13. FATHER'S NAME: Frank Zito

14. MOTHER'S MAIDEN NAME: Concetta Cisposda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Hypertensive Cardio-Vascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 22, 1949, *to* January 22, 1949, *that I last saw the deceased alive on* 1/22, 1949, *and that death occurred at* 11:15 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bobby L. Jones M. D.	Franklin Square Hosp.	1/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/25/48	Holy Redeemer	Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 24 1949	Huntington Williams, M.D.	Clarence F. Hoffmann 1639 Broadway.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 81 2 9 / N 803

Registered No. 6708835

1. NAME OF DECEASED (Type or Print): HURDON SCHULTZ

2. DATE OF DEATH: January 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. Gen. Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 43 N. Wheeler Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	Feb. 22, 1914	34	11 / 0	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blocker
10B. KIND OF BUSINESS OR INDUSTRY: Straw Hats
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Frank E. Schultz
14. MOTHER'S MAIDEN NAME: Sally Birkett
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): yes / II World War
16. SOCIAL SECURITY NO.: 212-05-8873
17. INFORMANT: Rosa S. Bell ADDRESS: 43 Wheeler Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Fracture of Skull	
	(B) Intracranial Hemorrhage	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Althol Avenue near German Aged Home North of Frederick Avenue
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: January 22, 1949 m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? "Hit and Run"

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 25-1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): Balto. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mr. Mrs. John W. Genfel & Sons ADDRESS: 170 C

VS 151

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) GEORGE L. LINSEY (ARTHUR LINSEY)

2. DATE OF DEATH January 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital
C. Length of stay in Baltimore 49 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 947 Etting Street 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored		Sept. 2 1899	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Benjamin Richard
14. MOTHER'S MAIDEN NAME Letta Covington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Letta Pinkbey ADDRESS 947 Etting St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic Cardiovascular Disease	
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
II	(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Osteomyelitis, left tibia	

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE John R Lewis M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED Jan. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/25/49	Mt. Calvary.	Cedar Hill Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 24 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR A. Halstead ADDRESS 918 Druid Hill Ave. 939

VS 151

Cause of death is important; please write the cause of death clearly and legibly.

G70837 Yha 2 ✓ 420.1 443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70837

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George H. Long

2. DATE OF DEATH: JAN 21 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 74 Yrs. ~~Mos. Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 111 S. Bouldin St 3 6 10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	6-19-75	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Railroader

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? ?

14. MOTHER'S MAIDEN NAME: ? ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute, anterior myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: ~~1~~ 10 days

DUE TO

(B) Hypertensive arterio Sclerotic cardio vascular disease — 10 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-19, 1949, to 1-21, 1949 *that I last saw the deceased alive on* 1-21, 1949, *and that death occurred at* 8.20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard S Rossi M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 1-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 25/49

24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn

24D. LOCATION (City, town, or county) (State): Balto Co Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949

REGISTRAR'S SIGNATURE: Lucien Williams, M.D.

25. FUNERAL DIRECTOR: Ulbut Funeral Home ADDRESS: 2008 Orleans

93D

G70838 CERTIFICATE CORRECTED 2-2-49 ✓ X

BALTIMORE CITY HEALTH DEPARTMENT 156.2 G70838

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Nilles

2. DATE OF DEATH 1/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arbutus
D. STREET ADDRESS (If rural, give location) 1236 Maple Avenue

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH 3/7/[illegible] | 9. AGE (In years last birthday) 54 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher | 10B. KIND OF BUSINESS OR INDUSTRY European Kosher | 11. BIRTHPLACE (State or foreign country) (Luxemburg) Luxembourg | 12. CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME John

14. MOTHER'S MAIDEN NAME ELIZABETH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 816-09-2465

17. INFORMANT Mrs Joseph Nilles ADDRESS 1236 Maple Ave Arbutus - Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adeno carcinoma, Liver, DUE TO Metastatic ca. Ovaries — INTERVAL BETWEEN ONSET AND DEATH Aprox 9 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 4/18/48 | 19B. MAJOR FINDINGS OF OPERATION Acute Pancreatitis. Metastatic carcinoma Liver | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/19, 1949 *to* 1/22, 1949, *that I last saw the deceased alive on* 1/22, 1949 *and that death occurred at* 9:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Rafael V. Ramos M. D. | 23B. ADDRESS St. Agnes Hospital | 23C. DATE SIGNED 1-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE Jan. 25'49 | 24C. NAME OF CEMETERY OR CREMATORY London Park | 24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 24 1949 | REGISTRAR'S SIGNATURE [illegible] | 25. FUNERAL DIRECTOR Harry A Witzke | ADDRESS

VS 150

469

G708.39 ✓ 420.1 G708.39

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Sedlacek

2. DATE OF DEATH: Jan. 21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1722 N. Bradford St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 58 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto. Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 1722 N. Bradford St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Mins.
Male	White	Single	July 26, 1877	71	5 / 25	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Czechoslovakia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Sedlacek

14. MOTHER'S MAIDEN NAME: Annie -Lalsnecka

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Barbara Louck, 1722 N. Bradford — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Interval between onset and death: Jan 20 & 1/4

DUE TO

(B) Chronic Myocarditis — July 1 48

DUE TO

(C) Arterio-Sclerosis — Jan 5. 44

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	-

22. *I hereby certify that I attended the deceased from* Jan 5 1944 *to* Jan 21, 1949, *that I last saw the deceased alive on* Jan 21 1949, *and that death occurred at* 10 30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William J Rycave M. D.	801 W Lemwood Rd	1/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 24/49	Oak Hill Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Philip Herwig Sons — ADDRESS: 2024 Orleans St.

937

VS 150

✓ 465

G708-20 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. G708-20

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Katie Pilgrim
2. DATE OF DEATH: 11/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ of Md Hosp
c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 4318 Reisterstown Rd 15 13

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Widowed	Aug 1866	82	3	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Md	

13. FATHER'S NAME: John Riely
14. MOTHER'S MAIDEN NAME: Nancie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: John H. Pilgrim, Son — ADDRESS: 4318 Granite Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonitis at Right Base — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO
(B) Possible Pulmonary Infarction
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes Mellitus

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 19 49 *to* Jan 23, 1949 *that I last saw the deceased alive on* Jan 23, 1949 *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank E Brumback M. D.	University Hospital	11/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 26/49	Morland Mem Pk	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams, M.D.	Philip Hennig Sons	2024 Eutaw St

VS 150

61

✓ 334

BIRTH NO. 6708-1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6708-1

1. NAME OF DECEASED (Type or Print): James Lang

2. DATE OF DEATH: 1-20-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1509 E. Chase St

C. Length of stay in Baltimore: 26 Yrs

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1509 E. Chase 7-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	M	11-24-1886	62	2 / 26	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Greenville N.C.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Nancy Barrett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Annie Lang ADDRESS: 1509 E. Chase

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Cerebral Apoplexy — 5 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 14, 1949 *to* Jan. 20, 1949 *that I last saw the deceased alive on* Jan. 14 1949, *and that death occurred at* 4 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm. P. Ray Perrin M. D.

23B. ADDRESS: 1420 E. Chase St.

23C. DATE SIGNED: 1-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE: 1-24-49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Byron T. Mamie Wright ADDRESS: 721 Augusta

VS 150

83a

G70842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 98315 H88313

Registered No. G70842

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Fred A Bolton

2. DATE OF DEATH: 1/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: 15 years. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1708 Hollins St. 19-C-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	March 3, 1875	73	10	18

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant of cake stall in market

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Worchester, Mass.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Millo Bolton MILO

14. MOTHER'S MAIDEN NAME: Mary Loring

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Edna Haskell Bolton ADDRESS: 1708 Hollins St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of skull

due to infected lacerations of scalp,

or meningitis (post-traumatic),

due to terminal bronchopneumonia.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Front of 1107 Hollins St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 12 49 9 P.m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Blunt instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: George L. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 1/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-24-49

24C. NAME OF CEMETERY OR CREMATORY: Louden Park

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Geo. L. Boyer Jr. ADDRESS: 1102 Hollins St.

VS 151

168

G70843 422.1(?) G70843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mary Jones Hurst Cookman

2. DATE OF DEATH: Jan-22-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3333 N Charles

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Balto City C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3333 N Charles St

5. SEX: Female 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow 8. DATE OF BIRTH: Dec-30-1861 9. AGE (In years last birthday): 87-0-23 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): (Her home) Charles Apts

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Hurst

14. MOTHER'S MAIDEN NAME: Annie — ? — 460 WILMSLOW RD.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Miss Catherine Hurst ADDRESS: 460 Wilmslow Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral Thrombosis — 1 year

DUE TO

(C) Arteriosclerosis — 1 year

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: — m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Jan 13th, 1949, *to* Jan 22nd, 1949, *that I last saw the deceased alive on* Jan 21st, 1949, *and that death occurred at* 2 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. A. Schustard M. D.

23B. ADDRESS: 1300 N. Calvert St

23C. DATE SIGNED: Jan 22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan-24-49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Stewart Mortuary ADDRESS: Balto.

83a

US 150

✓ 170

G 70844

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 70844

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Agnes C Oliver

2. DATE OF DEATH: 1-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General

c. Length of stay in Baltimore: 49 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1037 W. Barry St. 21-01

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year: Months / Days / Hours / Min.)
F	W	Married.	5/9/1899	49

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House work	at Home	Maryland.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John P. Morrissey	Julia Bruce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
✓	✓	✓	Mr John A. Oliver	1037 W. Barre St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia, bronchial — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma breast & metastasis.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
11-24-48	Carcinoma breast — left	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-4 19 48 *to* 1-23 19 49, *that I last saw the deceased alive on* 1-23 19 49 *and that death occurred at* 7 45 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sheldon R. MacDonald M. D.	1013 Light St.	1-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/27/49	St Peters Cem	1300 Moreland Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams, M.D.	John J. Cowan & Son	2 Collins St.

VS 150

50

G70845 ✓ 422.1 G70845

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): CATHERINE RYAN
2. DATE OF DEATH: 1/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1628 Cole St.
C. Length of stay in Baltimore: 78 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1628 Cole St. 19 04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	1/8/1871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	at Home	Maryland	U S A

13. FATHER'S NAME: John Kane
14. MOTHER'S MAIDEN NAME: Mary Madigan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
✓	✓	✓	Mrs Frances L. Stapleton	1628 Cole St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO

(B) pulmonary edema

DUE TO

(C) arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

senility

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 21 Jan, 1949 *to* 22 Jan, 1949, *that I last saw the deceased alive on* 21 Jan, 1949, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. H. Bayless M. D.	1600 Wilkens Ave	24 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/27/49	Holy Redeemer	4430 Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Penmanship for Williams, Mgr.	John J. Cowan & Son	2 Collins St.

937

✓ 475

G70846 — BALTIMORE CITY HEALTH DEPARTMENT — G70846

BIRTH NO. B.C. 48-19868 — **CERTIFICATE OF DEATH** — Registered No.

1. NAME OF DECEASED (Type or Print): RAYMOND L. PALMER, Jr.

2. DATE OF DEATH: Jan. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3915 Cranston Ave.

c. Length of stay in Baltimore: 4 mo 4 days (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3915 Cranston Ave. 16 08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	single	Sept. 17, 1948		4	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Baltimore, Md.	

13. FATHER'S NAME: Raymond L. Palmer, Sr.

14. MOTHER'S MAIDEN NAME: Alethea L. Feeser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT — ADDRESS: Mr. Raymond L. Palmer, Sr. 3915 Cranston Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) acute respiration infection (mass pharyngitis, laryngitis, bronchitis) probably a virus type	5 days.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) convulsions causing asphyxiation	20 min.
	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 4th, 1948, to Jan. 21, 1949, *that I last saw the deceased alive on* Jan 21, 1949, *and that death occurred at* 9:20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. H. Kemp M. D.	3030 Edmondson Ave.	Jan. 22 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/24/49	Pleasant Valley	Carroll Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

106a

G708.17 ✓410

St. F.X. Stevens
Harford & Hillen Rd.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G708.17

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Frederick Heins — 2. DATE OF DEATH: Jan. 21st, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2611 Ensor Ave 9-07

5. SEX: male — 6. COLOR OR RACE: white — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed — 8. DATE OF BIRTH: March 21 1867 — 9. AGE (In years last birthday): 81 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Asherman Nursing Home

c. Length of stay in Baltimore: Yrs. Mos. Days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter — 10B. KIND OF BUSINESS OR INDUSTRY: Baltimore City Fire Dept. — 11. BIRTHPLACE (State or foreign country): Germany — 12. CITIZEN OF WHAT COUNTRY?: U-S

13. FATHER'S NAME: Unknown — 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Jessie Albert — ADDRESS: Heins Apt Belvedere

MEDICAL CERTIFICATION

16. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronco Pneumonia — 2 days
DUE TO Uremia Coma — 10 days

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Interstitial Nephritis — 3 yrs
DUE TO Hypertension + Cardiac Sclerosis — 3 yrs

(C) Mitral Regurgitation Decompensated — 3 yrs
MITRAL REGURGITATION AND DECOMPENSATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 21, 1946 *to* Jan 21, 1949, *that I last saw the deceased alive on* Jan 20, 1949 *and that death occurred at* 2P *m., from the causes and on the date stated above.*

23A. SIGNATURE: J Ga Stevens M. D. — 23B. ADDRESS: 2918 Harford Rd. — 23C. DATE SIGNED: 1-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 1/24/49 — 24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem. — 24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949 — REGISTRAR'S SIGNATURE: Temperton Williams, M.D. — 25. FUNERAL DIRECTOR: Leonard J. Ruck — ADDRESS: 5305 Harford Ave.

VS 150

131a

BIRTH NO. G7084 8

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

260 Registered No. G7084 8

1. NAME OF DECEASED (Type or Print): Sara Elizabeth Halfpenny
2. DATE OF DEATH: 21 Jan. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp (DOA)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1441 Lowman St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24 01
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	2/23/1894	54 55	10			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Presser
14. MOTHER'S MAIDEN NAME: Connie C. Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-10-4367
17. INFORMANT: Proctor Jones Halfpenny ADDRESS: 1441 Lowman St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.
DUE TO
(B) Diabetes Mellitus
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 22 Jan. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/25/49	Cedar Hill Cem	G. G. Co.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Dill Bros. - 1501 E. Fort Ave.

VS 1511

61

G70849 — 342 — G70849

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): FRANK FRAER

2. DATE OF DEATH: 1-22-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: 40+ years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1407 Decatur Street 24-C-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	White	Married	May 13, 1895	53	8	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
B & O. railroad	sheet-metal worker	Hungary	U.S.A.

13. FATHER'S NAME: Dominic FRAER

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
NO		105-10-7340	Union Memorial Hospital Records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brain abscess

DUE TO

(B) etiology undetermined

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John D. Green, M. D.	Union Memorial Hosp.	1-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/25/49	Holy Cross Cemetery	Anne Arundel Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams, M.D.	Dill Bros.	1501 E. Fort Ave.

VS 150

802

G70850
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

353.3

Registered No. G70850

1. NAME OF DECEASED (Type or Print): ADDIE B. EVANS

2. DATE OF DEATH: January 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1374 Whatcoat Street 15-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	colored	single	June 19, 1927	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		South Carolina	

13. FATHER'S NAME: George Evans

14. MOTHER'S MAIDEN NAME: Irene Agers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		George Evans	1374 Whatcoat St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Epilepsy

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Carl L. Reyer M.D.	☐ / ☒ / ☐	Jan. 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1-24-49	Mount Calvary	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams, M.D.	George C. Kelson	

VS 151

85

✓ 019.2

G70851

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G50851

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BEATRICE FLETCHER

2. DATE OF DEATH: January 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1102 Pennsylvania Avenue

12-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
Female	Colored	Divorced	Jan. 2, 1914	35				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Balto., Md.	

13. FATHER'S NAME: Benjamin Adams

14. MOTHER'S MAIDEN NAME: Trease Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Rosetta Johnson	811 Tissier St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Miliary Tuberculous

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: John R Davis M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: Jan. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-25-49	Mt Auburn	md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949

REGISTRAR'S SIGNATURE: [illegible], M.D.

25. FUNERAL DIRECTOR: George A. Nelson ADDRESS: 1303 Pennsylvania Ave

VS 151

13C

✓ 151

G70852 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70852 — Registered No.

1. NAME OF DECEASED (Type or Print): Gertrude Wright

2. DATE OF DEATH: January 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Yrs. 14 Mos. 03 Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 564 Baker St

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify)
8. DATE OF BIRTH: 7/4/1898
9. AGE (In years last birthday): 51 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: 1/21/49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Stomach
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/20, 1949, *to* 1/21, 1949, *that I last saw the deceased alive on* 1/21, 1949, *and that death occurred at* 3:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Bobby L. Jones, M. D.
23B. ADDRESS: Franklin Square Hosp
23C. DATE SIGNED: 1/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 1/27/49
24C. NAME OF CEMETERY OR CREMATORY: mt auburn
24D. LOCATION (City, town, or county) (State): md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George E. Nelson — ADDRESS: 1383 Preston St

VS 150

46B

G708:53 ✓ 016

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G708:53

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nicholia Ehling

2. DATE OF DEATH: January 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 29 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2019 Annapolia Rd. 21-33

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year, last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	12-12-19	30	1	12	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber	Self	Md.	

13. FATHER'S NAME: Bernard Ehling

14. MOTHER'S MAIDEN NAME: Suzzanna Till

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	2 wks
DUE TO (B)	Genito-urinary tuberculosis	12 yrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-9 1949 *to* 1-23, 1949 *that I last saw the deceased alive on* 1-23, 1949, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William W. Winternitz M. D.	JOHNS HOPKINS HOSPITAL	1-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-26-49	Glen Haven	Anne Arundel County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	for Huntington Williams, M.D.	George L. Schwab	2101 Frederick Ave.

VS 150

20

Dr Cook 2431 Md Ave

G7708:54 BALTIMORE CITY HEALTH DEPARTMENT 334 G7708:54

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) CHARLES C. TERRY
2. DATE OF DEATH Jan 23-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2408 Barkley
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Md. b. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
c. Length of stay in Baltimore 5 yrs. Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location) 2408 Barcley St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. If under 1 year, last birthday) Months	Days	If under 24 hours Hours	Min.
Male	White	Married	March 30-1881	67			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	Farmer	Va	

13. FATHER'S NAME William
14. MOTHER'S MAIDEN NAME Lou Blankinship

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	Hattie Terry	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Vascular Accident 3 days with right hemiparaplegia.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 20 Jan, 1949 *to* 23 Jan, 1949, *that I last saw the deceased alive on* 22 Jan, 1949, *and that death occurred at* 8:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. Ellsworth Cook M. D.	2431 Maryland Ave	24 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 49	Presbyterian Cemetery	Turbeville Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams M.D.	Frank H Seitz	814 N 36th St

83a

G70855 ✓ 583 G70855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) MINNIE DREXLER

2. DATE OF DEATH 1/22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1921 N Gollington Ave 8 02
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1921 N Gollington Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White		Jan 26 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Henry Swantmyer
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS John P. Drexler 1921 N. Gollington Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolus
DUE TO
(B) Obstructive Jaundice
DUE TO
(C) Hepatic Insufficiency

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/15/48 19 , *to* 1/22 , 1949, *that I last saw the deceased alive on* 1/22 , 1949, *and that death occurred at* 4:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Benson Schwartz M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 1/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 6 1949
24C. NAME OF CEMETERY OR CREMATORY Baltimore
24D. LOCATION (City, town, or county) (State) E. North Ave Ext

DATE RECEIVED BY LOCAL REGISTRAR JAN 24 1949
REGISTRAR'S SIGNATURE Huntington Williams, Md
25. FUNERAL DIRECTOR ADDRESS Leo. B. Leo 1703 N. Patterson Park ave

127B

B.C. 46852

G70856

✓ 591.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70856

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Gertrude Moore

2. DATE OF DEATH: January 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. 6 Mos. Days

D. STREET ADDRESS (If rural, give location): 823 W. Franklin St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	Colored	Child	July 29, 1948		6			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Dewsbery Moore

14. MOTHER'S MAIDEN NAME: Lizie May Hill ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACIDOSIS WITH DEHYDRATION — Interval between onset and death: 2 days

DUE TO

(B) DIARRHEA, ETIOLOGY UNKNOWN — 2 days.

DUE TO

(C) ? BRONCHIOLITIS — 4 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-22, 1949 *to* 1-22, 1949 *that I last saw the deceased alive on* 1-22, 1949, *and that death occurred at* 4 55 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dan C. Neumann M. D.	JOHNS HOPKINS HOSPITAL	1-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	January 26 49	Mount Lion Cemetery	Baltimore City Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Joseph A. Lively ADDRESS: 661 W. Lanvale St

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070857 ✓ 450,0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 070857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6816 Reisterstown Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6816 Reisterstown Rd. 38 01
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Matilda Barnett

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank A. Barnett
6 (c) If alive, give age 93 years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1855

8. AGE: Years	Months	Days	If less than one day
94		19	hr. min.

9. Birthplace Maryland (Balto. Co.)
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick C. Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Eliza Jane Johnson
15. Birthplace Maryland

16 (a) Informant Florence A. Barnett
(b) Address 6816 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/49 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cem.
Location Randallstown, Md.

18 (a) Funeral director Wm. J. Tickner & Son
(b) Address North & Penna Ave. Balto., Md.

19 (a) JAN 24 1949 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1949 at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Many years 9 to Jan. 23, 1949, and that I last saw her alive on Jan. 22, 1949

Immediate cause of death	Duration
Arterio Sclerosis	
Due to	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. C. Nichols Jr. M.D.
Address Pikesville-8, Md. Date signed 1/24/49

VS 3

97

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C70858

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

334 Registered No. C70858

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDNA WARFIELD CROMWELL

2. DATE OF DEATH 1/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glyndon
D. STREET ADDRESS (If rural, give location) 412 Butler Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W		1/14/80	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md	U.S.

13. FATHER'S NAME Henry W. Warfield
14. MOTHER'S MAIDEN NAME Sarah E. Whalen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		no	Miss Mary E. Cromwell	Glyndon 412 Butler Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT Enlarged thyroid gland.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/20 1949 to 1/24 1949 *that I last saw the deceased alive on* 1/23 1949 *and that death occurred at* 12-25 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Charles J. Blank | 23B. ADDRESS Maryland General | 23C. DATE SIGNED 1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1/26/49 | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | 24D. LOCATION (City, town, or county) (State) Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 24 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR WM. J. TICKNER & SONS | ADDRESS Balto., Md.

83 t

420:1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 6708 59 — Registered No. 6708 59

1. NAME OF DECEASED (Type or Print): Harry L Stephan

2. DATE OF DEATH: 1-23-49.

3. PLACE OF DEATH: A. Baltimore City, Maryland — B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ~~University Hospital~~ ~~Home~~ ~~Dead on Arrival~~

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE — B. COUNTY: 1022 W Bare St 21-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md

D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	Sept 15-1895	53	7 / 8	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Bakery	Baltimore Md	—

13. FATHER'S NAME: Harry Stephan

14. MOTHER'S MAIDEN NAME: Katherine Virginia Boglow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service): no

16. SOCIAL SECURITY NO.: 215-03-8414

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion - Acute. — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 yr

DUE TO

(B) Coronary Artery Sclerosis.

DUE TO

(C) Hypertension Essential

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1947 19__ *to* 1-23-49 19__, *that I last saw the deceased alive on* 1-23-49 19__, *and that death occurred at* 6.00 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. E. Kaufman M.D.	64 N 4th St. Balt	1-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Jan 27-49	Loudon Park Cemetery	Baltimore Md

DATE RECEIVED: JAN 28 1949 — REGISTRAR — ~~Washington Millburn, MD~~

25. FUNERAL DIRECTOR — ADDRESS: Bernard A. Finn 3603 Belair Rd

VS 150

94a

AB-126137
G70860

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

002

Registered No. G70860

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thomas Samuel Kane

2. DATE OF DEATH Jan. 22-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue

C. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1109 Montpelier St. 9 04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Dec. 23- 1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME Thomas Kane

14. MOTHER'S MAIDEN NAME Elizabeth Burnet

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	219-16-8169	Records-Baltimore City Hospitals	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pulmonary tuberculosis	1 yr & more
DUE TO		
ANTECEDENT CAUSES (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. Shyle Bruton, M.D. M. D.	Baltimore City Hospitals	1/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-25-49	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams, M.D.	John A. Moran	330 E. Balt. St.

VS 150

12 B

✓422.1

G70861

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70861

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sallie E. Wilmer

2. DATE OF DEATH: Jany 24/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Lee Billows Unit

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgewood Nursing Home

C. Length of stay in Baltimore: 50 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission): A. STATE — B. COUNTY: 1429 Bolton St Balto. Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md

D. STREET ADDRESS (If rural, give location): 1429 Bolton St 14 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	single	Nov. 2 1869	79 74	2 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Centreville Md	

13. FATHER'S NAME: John W. Wilmer

14. MOTHER'S MAIDEN NAME: Sarah H. Nicholson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT — ADDRESS
no no	xxx	John W. Webb

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Arteriosclerotic C.V. Disease — DUE TO Aortic stenosis.

(B) Chronic Myocarditis — DUE TO senility.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 26 July, 1947, *to* 24 Jan, 1949, *that I last saw the deceased alive on* 24 Jan, 1949, *and that death occurred at* 9:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph E. Muse Jr. M. D.	5 West 29th St.	24 Jan '49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	JAN. 26, 1949	Chesterfield Cemy.	Centerville, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 24 1949	Huntington Williams, M.D.	John O. Mitchell Sons 1900 Eutaw Place

920a

✓ 241

G70862

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70862
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EARLE G. BENNETT
2. DATE OF DEATH: 1/22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 3001 The Alameda
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 3001 The Alameda 9 06

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	white	Married	3/24, 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chief Fire Alarm &	Telegraph	Baltimore Md.	U.S.A.

13. FATHER'S NAME: Louis T. Bennett
14. MOTHER'S MAIDEN NAME: Emma A. Silence

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT (ADDRESS)
No		Elizabeth G. Bennett — 3001 Alameda Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 years.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bronchial Asthma — 10 years
DUE TO

(C) ✓
✓

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	✓	✓

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
✓ m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	✓

22. *I hereby certify that I attended the deceased from* Jan. 17, 1939 *to* Jan. 22, 1949, *that I last saw the deceased alive on* Jan. 23, 1949, *and that death occurred at* 7:30 *a. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas. G. Evans Son Inc.	2701 N. Calvert 118 N. Mt. Royal Ave	Jan. 23, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/26/49	Holy Redeemer	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR (ADDRESS)
JAN 24 1949	Huntington Williams, M.D.	Chas. G. Evans - Son. Inc. 118 N. Mt. Royal Ave 21231

VS 150

G70863 B.C. 49-00761 ✓ 776 G70863

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. G70863 Registered No. G70863

1. NAME OF DECEASED (Type or Print): ELORRIE MAXINE WEAVER. 2. DATE OF DEATH: 1/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: D.C.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): D.C.
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 hours: Hours, Min.
F	W	S	1/14/49	—	9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Newborn	—	USA - Maryland	USA

13. FATHER'S NAME: DEAN RAY WEAVER
14. MOTHER'S MAIDEN NAME: MADELINE ELSIE HUBLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		—	above	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory failure — Interval between onset and death: 10 days.
DUE TO
(B) Premature birth — Interval between onset and death: 1
DUE TO
(C) —

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: —

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 1/14, 1949 *to* 1/23, 1949 *that I last saw the deceased alive on* 1/22, 1949 *and that death occurred at* 2:10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm A Makwell M. D.	St Agnes	1/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/24/49	Holy Redeemer	Belair Rd Waverly

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Evelyn Williams, M.D.	Frank Pelly Sons	

VS 150

159

✓ 450.0

G70864

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70864

1. NAME OF DECEASED (Type or Print): John Applewhite

2. DATE OF DEATH: 1/31/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4801 Hilton Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 3 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 27-09
4801 Hillen Rd
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 12, Md
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	Married	1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ministry		Jackson, Miss.	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Hester Davis - 4801 Hillen Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Arteriosclerosis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-17, 19 49 *to* 1-21, 19 49 *that I last saw the deceased alive on* 1-21 19 49 *and that death occurred at* 4:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mark T. Waddell M. D.	861 Harlem ave	1/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-25-49	Mt. Auburn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 24 1949	Huntington Williams, M.D.	Charles R. Law - 802 Mad. ave.

VS 150

107

G70865 ✓ 146 G70865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) LOUIS DONALD DARNELL

2. DATE OF DEATH January 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S. Marine Hospital Wyman Park Drive & 31st St.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 636 Bruce St. 16-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	col	Single	3/1/90	58	10	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	-	Annapolis, Md.	USA

13. FATHER'S NAME Phillip Darnell

14. MOTHER'S MAIDEN NAME Louise Blake

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WW I	?	Records- USMH- Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of the Nasopharynx	Unknown
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov. 30, 1948 *to* Jan. 19, 1949, *that I last saw the deceased alive on* Jan. 19, 1949, *and that death occurred at* 8:45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Victor A. McKusick M. D.	U. S. Marine Hosp.	1/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	1/23/49	Baltimore Memorial Gardens	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 24 1949	Huntington Williams, MD	Elroy O. Wilson	900 Bruntz Rd

VS 150

45F

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): BRADLEY THEODORE JOHNSON	2. DATE OF DEATH: Jan.22,1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1705 E. LaFayette Ave.	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
c. Length of stay in Baltimore: Yrs. Mos. Days	D. STREET ADDRESS (If rural, give location): 1705 E. Lafa yette Ave. 8 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	Sept. 1898	50	4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George M. Johnson	Alice Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	Mrs Hilda Standford, 1705 E. LaFayette Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Tuberculosis	25 yrs
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Morphine addiction	25 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept, 1947 *to* Jan. 22, 1949 *that I last saw the deceased alive on* Jan 15, 1949, *and that death occurred at* 5 am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Conrad H. Rusch M. D.	1906 N Wash St	1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	1/25/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 25 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. SADIE BELLE JORDAN
2. DATE OF DEATH: Jan 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hosp.
C. Length of stay in Baltimore: 64 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1212 N. Chester St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	6/5/1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Maryland	U. S.

13. FATHER'S NAME: Charles M. Geyer
14. MOTHER'S MAIDEN NAME: Elizabeth Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Earl Jordan	1217 N. Chester st.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes Mellitus

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 22, 1949 *to* Jan 23, 1949 *that I last saw the deceased alive on* Jan 23, 1949 *and that death occurred at* 9:40 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Karl E. Persons Jr. M.D.	St. Josephs Hosp.	1/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-27-49	Oak Lawn	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 25 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Carlene Gwen Sullivan

2. DATE OF DEATH 1/24/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto - Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore 7 days. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 6123 Toone St 26 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W		1/16/49			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore Md	

13. FATHER'S NAME John Linwood Sullivan

14. MOTHER'S MAIDEN NAME Lone Cissell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			John Sullivan	6123 Toone St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIO - RESPIRATORY FAILURE

DUE TO

(B) MENINGITIS (OVERWHELMING)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/16/49, 19__, *to* 1/24, 1949 *that I last saw the deceased alive on* 1/24, 1949 *and that death occurred at* 6:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. H. Shaw M. D.	St. Agnes Hosp	1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/25/49	Prospect Hill	Towson Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 25 1949	Huntington Williams, M.D.	Milhoan & Son	1214 Eutaw St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

491 G7085 9

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY HARE

2. DATE OF DEATH Jan 22-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4111 Chatham Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4111 Chatham Rd

c. Length of stay in Baltimore 12 yrs 10 mos

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 4111 Chatham Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Feb. 17-1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H. Wife	at home	Virginia	U.S.A.

13. FATHER'S NAME Joseph H. Hansell

14. MOTHER'S MAIDEN NAME Catherine Carrier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	none	Mrs Jesse Rothenberg	4115 Chatham Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

(B) Secondary anemia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	✓	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
✓	✓	✓

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* July 1948 *to* Jan 22, 1949 *that I last saw the deceased alive on* Jan 22, 1949, *and that death occurred at* 11 25 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benj. Sachs M. D.	2128 W. Monty Cir	1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-25-49	Meadow Ridge Cem	Balto. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 25 1949	Contingent for Williams, M.D.	E. W. Lamoreaux 4510	Liberty Rd Balto Co

VS 150

107

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BELLE MC CARTY

2. DATE OF DEATH: 1-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 704 Washburn Ave. 2-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	white	W.	7-6-1878	70	6 16	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Virginia	

13. FATHER'S NAME: unk

14. MOTHER'S MAIDEN NAME: unk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		Family	Same.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Coronary Occlusion with
(B) Embolic & Peripheral Circulation
DUE TO Cerebro Vascular Accident
(C) Arteriosclerotic Cardio Vascular Disease

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
January 10 1949	Surviving Acute Cholecystitis & Adeliti Liasis	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-31-48 *to* 1-22-49, *that I last saw the deceased alive on* 1-22-49, *and that death occurred at* 9:15 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edgar A. Rodriguez M. D.	St Agnes Hospital	1-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	1-25-49	Cedar Hill	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 25 1949	Huntington Williams, M.D.	James L. McCauley	330 S. Fort Ave. 126

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANK JONES

2. DATE OF DEATH: Jan. 23. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 907 N. Lakewood Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At. Home
c. Length of stay in Baltimore: 70 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 907 N. Lakewood Ave. 8 c 3

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Jul. 21. 1868
9. AGE (In years last birthday): 80 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cunductor
10B. KIND OF BUSINESS OR INDUSTRY: Balto. Transit. Retired.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Jones
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. Frank S. Jones ADDRESS: 907 N. Lakewood Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CEREBRAL HEMORRHAGE	1 HR.
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	GENERALIZED ARTERIOSCLEROSIS	20 yrs.
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* FEB. 1946 *to* JAN. 23 1949 *that I last saw the deceased alive on* JAN. 22 1949 *and that death occurred at* 9.30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Benjamin Highstein M. D.
23B. ADDRESS: 121 S. HIGHLAND AVE.
23C. DATE SIGNED: JAN. 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 28. 1949
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY REGISTRAR: JAN 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC. ADDRESS: Baltimore Md.

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ANNA KUCERA

2. DATE OF DEATH: Jan. 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 716 N. Luzerne Avenue Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 716 N. Luzerne Avenue 7-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
female	white	married	Jan. 1, 1890	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	U.S.

13. FATHER'S NAME: John J. Gaff

14. MOTHER'S MAIDEN NAME: Teresa M. Werner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		216-05-4568	Mr. Otto Kucera	716 N. Luzerne Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Diabetes Mellitus

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 22, 1948 *to* Jan 22, 1949, *that I last saw the deceased alive on* Jan 22, 1949, *and that death occurred at* 4.30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm J Schmit M. D.	701 N. Kenwood Ave.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 26, 1949	Holy Redeemer Cemetery	4430 Belair Road, Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 25 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MAMIE EDMONDS

2. DATE OF DEATH: January 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 2days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Talbot
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Michaels
D. STREET ADDRESS (If rural, give location): St. Michaels Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Married	March 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Talbott Co.	Talbott Co.

13. FATHER'S NAME: Andrew C. Barkman

14. MOTHER'S MAIDEN NAME: Elizabeth Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Philip Edmonds	St. Michaels Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-sclerotic — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cardio-vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: January 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Thurs. Jany 27	Olivet Cemetery	St Michaels Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John O Mitchell & Sons — ADDRESS: 1900 Eutaw Place

John O. Mitchell 93D

VS 151

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elmer J.Lewis.

2. DATE OF DEATH: 1/23/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2043 E.Hoffman St.

c. Length of stay in Baltimore: Yrs. Life. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2043 E.Hoffman St. 8 07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male.	White.	Single.	2/10/1897	51 52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Lewis.

14. MOTHER'S MAIDEN NAME: Anna Bratigan.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes. (If yes, give war or dates of service): 1st W.W.

16. SOCIAL SECURITY NO.: 219-12-8314

17. INFORMANT: John Lewis. ADDRESS: 2043 E.Hoffman St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

(B) Chronic Arthritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 23, 1949 *to* Jan 23, 1949 *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Karol Fraiken M. D.

23B. ADDRESS: 1823 N. Wash. St

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/26/49

24C. NAME OF CEMETERY OR CREMATORY: National

24D. LOCATION (City, town, or county) (State): Frederick Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Paul E.Chenoweth Jr ADDRESS: 3615-17 Chestnut Ave.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G708?5

BIRTH NO. PETTWAY

1. NAME OF DECEASED (Type or Print): Leroy Pettway

2. DATE OF DEATH: Jan. 23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
4940 Eastern Avenue

c. Length of stay in Baltimore: 19yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Rural- Essex
D STREET ADDRESS (If rural, give location): 400 Wise Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	Married	Sept-30-1906	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	Automobiles	Virginia	USA

13. FATHER'S NAME: Edward Pettway

14. MOTHER'S MAIDEN NAME: Alma Ford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	—	—	Records	Baltimore City Hospitals 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction, posterior — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic coronary artery disease

DUE TO

(C) Pulmonary edema

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-23-49, 1949, *to* 12 noon 1-23 1949, *that I last saw the deceased alive on* 1-23, 1949, *and that death occurred at* 12 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David H. Marine M. D.	Balto City Hospitals	1-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/28/49	Woodlawn Cem.	Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 25 1949	Huntington Williams, M.D.	John J. Cowan & Son	2 Ellis St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Paul Frederick Hamm
2. DATE OF DEATH: January 22, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland; B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 820 S. Highland 26 11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	married	4/19/03	45	9	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stock clerk		Baltimore	U.S.

13. FATHER'S NAME [redacted] HAMM
14. MOTHER'S MAIDEN NAME: CATHERINE DISTLER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 315-10-5476
17. INFORMANT: JOSEPHINE HAMM ADDRESS 820 S HIGHLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiac Failure — DUE TO

(C) Hypertensive Heart disease

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: pneumonia, Left Apex

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 19, 1949, to Jan 22, 1949, that I last saw the deceased alive on Jan 21, 1949, and that death occurred at 5:45a m., from the causes and on the date stated above.

23A. SIGNATURE: Philip A. Peter M.D. M. D. | 23B. ADDRESS: 1400 N. Caroline St. | 23C. DATE SIGNED: Jan 22 '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 1-26-49 | 24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Mem | 24D. LOCATION (City, town or county) (State): Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 25 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR, ADDRESS: Charles L. Zeiler, 901 E. Conkling St.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ellen Durkin
2. DATE OF DEATH: Jan 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Hosp. Osler 4
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 14 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 1-Ol
D. STREET ADDRESS (If rural, give location): Orange Grove 727 S. Ellwood Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	White	Child	2-5-34	14 yrs	11	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Md.	USA

13. FATHER'S NAME: John Durkin
14. MOTHER'S MAIDEN NAME: Mary Novak

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Rheumatic Heart Disease	2 yrs.
	DUE TO	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 1-11-49, 1949 *to* 1-22-49, 1949 *that I last saw the deceased alive on* 1-22-49, 1949 *and that death occurred at* 7:25 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin E. Sprunt M. D.	JOHNS HOPKINS HOSPITAL	1/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-26-49.	Holy Redeemer Cem.	Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 29 1949	Huntington Williams, M.D.	Leander L. Zeiler 901 S. Conkling St.

VS 150

587

G708.8 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 G708.8 Registered No.

1. NAME OF DECEASED (Type or Print): SADIE SPENCER GUCE

2. DATE OF DEATH: 1/22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1106 Harlem Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 25-32
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md
D. STREET ADDRESS (If rural, give location): 1306 Shellbank Road

5. SEX: F
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH
9. AGE (In years last birthday): 69 | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. W
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alex Thomson
14. MOTHER'S MAIDEN NAME: Mary Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Howard Spencer ADDRESS: 1306 Shellbank Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1/22/49
DUE TO
(B) Hypertensive — 9 mos.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/20 1949 to 1/22 1949 that I last saw the deceased alive on 1/22/49 and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE: H. Williams
23B. ADDRESS: 1131 Harlem Ave
23C. DATE SIGNED: 1/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/26/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Isaac L Brown Son ADDRESS: 108 W Montgomery St

VS 150

83a

G708.79 ✓ 422.1 G708.79

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Carter. | 2. DATE OF DEATH: January 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: Balto. Co.

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-03

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 843 Harlem Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	C	Separated	2-22-1889	59	11			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Howard County, Md.	U. S. A.

13. FATHER'S NAME: William Carter.

14. MOTHER'S MAIDEN NAME: Maria Fuller.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—		Rev. John H. Carter,	214 Center St. Trustee Statistical

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-Sclerotic Cardiac

DUE TO

(B) Pneumonia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
Earl L. Kay M.D.		23 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 26, 1949	Arbutus Memorial	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 25 1949	Huntington Williams, M.D.	Mrs Katie R Williams	3221 Schroeder St.

VS 151

937

G70830

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

332 - G70830

Registered No.

1. NAME OF DECEASED (Type or Print): Annie Smith.

2. DATE OF DEATH: January 12, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1621 Harlem Ave.

C. Length of stay in Baltimore: 27 Years. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: U.S.A.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1621 Harlem Ave. 16-03

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: April 30, 1890.
9. AGE (In years last birthday): 58 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bolton, N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Freeman.
14. MOTHER'S MAIDEN NAME: Emma

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Bertha Joynes. ADDRESS: 1621 Harlem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Embolism	7 days
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Pernicious Anemia	5

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 1-15, 1949 *to* 1-25, 1949, *that I last saw the deceased alive on* 1-25, 1949, *and that death occurred at* 11:25 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Clifford P. Saunders M. D.
23B. ADDRESS: 2309 Druid Hill Ave.
23C. DATE SIGNED: 1-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 27, 1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 25 1949
REGISTRAR'S SIGNATURE: Thurlington for Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams
ADDRESS: 3224 Edmondson Ave

VS 150

83 B 1

G70881 ✓ 442 G70881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lonie Mae Mayfield

2. DATE OF DEATH: Jan. 22, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 918 Mount St..

c. Length of stay in Baltimore: 9 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 918 Mount St.. 16 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	C	Married	2-9-1898	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chester, S.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Jim Woodard.

14. MOTHER'S MAIDEN NAME: Laura Kenny.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Lucille Mayfield ADDRESS: 918 Mount St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive & arteriosclerotic cardiovascular renal disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 47 to Jan 22, 1949 *that I last saw the deceased alive on* Jan 21, 1949, *and that death occurred at* 8:40 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Thorofsky M.D. M. D.

23B. ADDRESS: 601 N. Monroe St.

23C. DATE SIGNED: 1/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 26, 1949

24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Mrs Kate B Williams

ADDRESS: 332 V Schroeder St

VS 150

131a

G70883 CERTIFICATE CORRECTED 2-1-49 ✓ 422.1 G70883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN CAHILL

2. DATE OF DEATH January 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital

c. Length of stay in Baltimore 50 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 511 S. Curley St. 1-0 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	2/5/~~1848~~ 1879	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Connecticut	U.S.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Brigid ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
Yes Spanish-American		Daisy Cahill - 511 S. Curley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/27/49	Baltimore, National	Frederick Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 25 1949	Huntington Williams, M.D.	Lilly & Zeiler, Inc. - 403 S. Wolfe St.

VS 151

937

GM 70883 123732 CERTIFICATE CORRECTED 8-26-52 G70883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Theodore Witzgall

2. DATE OF DEATH: 1- 24- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore (Yrs. Mos. Days): Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 103. Homewood St (1946) State Sanitorium

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	W	Sep.	Feb. 17-1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	

13. FATHER'S NAME: Adam (D)

14. MOTHER'S MAIDEN NAME: Catherine Gritzen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		Records Balto. City Hospitals 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory ~~Tuberculosis~~ failure — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) radiation therapy for CA of oesophagus — DUE TO — mos

(C) Pulm Tbc — yrs

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
10/1/48	normal anatomy	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
10 13 48 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10/25, 1948 *to* 1/24, 1949 *that I last saw the deceased alive on* ~~1/23~~ 1/24, 1949 *and that death occurred at* 6[15] A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jordan Craft M. D.	Balt. City Hosp. Balt. Md	1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/26/49	Balto Cem	W North ave Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 25 1949	Huntington Williams, M.D.	Edward Foulson	Work Pl

VS 150

46a

G70884

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

434.3 G70884

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): PAULINE RUHLAND

2. DATE OF DEATH: January 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 910 S. Curley Street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 910 S. Curley St 1-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	12/24/07	41 42	1	0	0	0

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor	National Can	Baltimore, Md	America

13. FATHER'S NAME: Frank Ograkiewski

14. MOTHER'S MAIDEN NAME: Frankowska

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Charles H. Ruhland ADDRESS 910 S. Curley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertrophy and dilatation of heart.
Acute congestive cardiac failure.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 1-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/28/49	Holy Rosary	Gernon Hill Rd.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John J. Duda ADDRESS 2829 Loudon Av.

95c

VS 151

GM. 125989

70885

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70885

Registered No.

1. NAME OF DECEASED (Type or Print): Frank. W. Carman Sr.

2. DATE OF DEATH: 1-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 506 Normandy Ave Z17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	Oct. 19 1882 ?	66?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INSPECTOR	GENERAL ELEVATOR CO	INDIANA	

13. FATHER'S NAME: (D) Late Wm T. CARMAN

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	216-05-8603	Records B lto. City Hospital	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO

(B) Bronchial Asthma — 4 yrs.

DUE TO

(C) Arteriosclerotic Heart Disease (5 yrs)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 11, 1949, *to* Jan 24, 1949, *that I last saw the deceased alive on* Jan 24, 1949 *and that death occurred at* 8 20 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John E. Rechtold M. D.	Balto City Hosp.	Jan 24 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JAN. 27, 1949	LORRAINE PARK	WOODLAWN MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 25 1949	Huntington Williams M.D.	Harry A Witzke	4101 Edmondson Ave

VS 150

937

G70886 ✓E812.4 N862 G70886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GERTRUDE POTTS

2. DATE OF DEATH: January 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
c. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1608 E. Hoffman Street 8 07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	Colored	Married	April 12, 1905	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Westchester, Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Spriggs
14. MOTHER'S MAIDEN NAME: Ella Melton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Abraham Potts ADDRESS: 1608 E. Hoffman Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Crushed chest
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street--Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): University Parkway & Canterbury Rd. 12/1
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 21, 1949 m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Carl L. Rogers M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Jan. 25, 1949
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): West Chest r Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 25 1949
REGISTRAR'S SIGNATURE: Evelyn Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Mrs. Robt. A. Elliott & Daughter, 1129 N. Caroline Street

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170 C

G70887 ✓ 422.1 G70887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RICHARD E. SMITH

2. DATE OF DEATH: Jan. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1903 Longwood St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1903 Longwood St. 15 6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Widowed	Sept. 27, 1882	66 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
- Smith	-

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Mr. R. H. Smith	2835 Ashland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — DUE TO

(C) Myocarditis

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertrophy

INTERVAL BETWEEN ONSET AND DEATH: 2 ½ yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* Jan. 24, 19 49, *that I last saw the deceased alive on* Jan. 24, 19 49, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. E. Keedle M. D.	3314 - 28. North Ave	Jan. 24/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/26/49	Western Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

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G70888 ✓ 334 G70888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ALEXANDER WRIGHT DURFEE

2. DATE OF DEATH: Jan. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1905 W. Saratoga St.
c. Length of stay in Baltimore: 50 yrs. (Yrs., Mos., Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1905 W. Saratoga St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	Aug. 20, 1870	78 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired Police Sgt.	City of Balto.	Shelburne, Nova Scotia	

13. FATHER'S NAME: Robert Durfee

14. MOTHER'S MAIDEN NAME: Sarah Peppett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no			Mrs. Annie V. Durfee	1905 W. Saratoga St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Apoplexy	
DUE TO (B)	Cerebral arterio sclerosis	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Senility	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
None	None	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4 Jan, 19 49, *to* 25 Jan, 19 49 *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. Bruce Brune M. D.	1033 W Lexington	1/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/27/49	Lorraine	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	Wm. J. TICKNER & SONS	Balto., Md.

VS 150

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G70889 ✓ 290.0 G70889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. Young

1. NAME OF DECEASED (Type or Print): Minnie L White

2. DATE OF DEATH: 1-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq. Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt.
D. STREET ADDRESS (If rural, give location): 1703 Barclay St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C		8/29/1890	58	4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housf.		Md.	

13. FATHER'S NAME: Josiah White

14. MOTHER'S MAIDEN NAME: Hannah (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		Husband.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pernicious Anemia — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Fibroid Uterus; Hemorrhagic cystitis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	As above	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-11, 1949 *to* 1-24, 1949, *that I last saw the deceased alive on* 1-24, 1949, *and that death occurred at* 7 25 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. J. Laham M. D.	Franklin Sq. Hosp.	1-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/27/49	Mt. Calvary	Anne Arundel, County

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 25 1949	Huntington Williams, M.D.	Joseph D. Rocks	1304 N. Central Ave

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G70890 ✓420.1 G70890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Marvin Coffman

2. DATE OF DEATH: 24 Jan. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital (DOA)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 425 N. East Avenue 26 10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		8/ 8/ 94	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Steamfitter		Pennsylvania	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Albert	Mary Gladhill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Frances Coffman	425 N. East Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Wm. H. Kammer Jr. M.D.	☐ / ☐ / ☑	25 Jan. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/28/49	Oak Lawn	Eastern Avenue Ext.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 25 1949	Huntington McMechen, M.D.	Lilly & Zeiler, Inc,	403 S. Wolfe Str.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 670891

1085 17 S. Pre Hosp Disposal ✓ X 776

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby Boy Brown

2. DATE OF DEATH: Jan. 20, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Ba. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Reisterstown
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Negro		Jan 20, 49			5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	—	

13. FATHER'S NAME: Leo Brown -

14. MOTHER'S MAIDEN NAME: Eliza ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
			JOHNS HOPKINS HOSPITAL TULPSOR SHIRJON CORP.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 20, 1949 *to* Jan 20, 1949 *that I last saw the deceased alive on* Jan 20, 1949 *and that death occurred at* 1 35 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Eugene O. Goldstein M. D.	JOHNS HOPKINS HOSPITAL	1/21/48

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	1/21/48	Hosp Disposal	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 25 1949	Huntington Williams, M.D.		

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G70892

BIRTH NO. B.C. 49-01243

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓X 761.5 G70892

Registered No.

1. NAME OF DECEASED (Type or Print): INFANT BOY SNYDER

2. DATE OF DEATH: JANUARY 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parkton
D. STREET ADDRESS (If rural, give location): (Rural, Parkton)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	—	January 22, 1949		—	—	5	35

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Baltimore Md.	—

13. FATHER'S NAME: William R. Snyder

14. MOTHER'S MAIDEN NAME: Ruth Dix

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity (28-30) wks gestation

DUE TO

(B) Premature Separation of Placenta

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 22, 1949, *to* Jan 22, 1949, *that I last saw the deceased alive on* Jan 22, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C. DATE SIGNED
Albert R. Milan M. D.	Union Memorial Hosp.	Jan 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 25 1949	Huntington Williams, MD		

160c

G70893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B.C. 48-20755 30F

Registered No. G70893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 14-03
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Penn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1948

8. AGE: Years | Months: 1 | Days: 11 | If less than one day: hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Roland Penn
13. Birthplace Virginia

MOTHER
14. Maiden Name Marie Gwaltney
15. Birthplace Waverly, Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Destroyed by Fire

18 (a) Funeral director
(b) Address

19 JAN 25 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 1 - 1948 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1948 to 11-1 1948, and that I last saw h/ alive on 11-1-1948

Immediate cause of death: Congenital Lues — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. W. Hoffler M. D.
Address President Hosp. Date signed 1/18/49

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G70894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

422.2

Registered No. G70894

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY M. WILLIAMS

2. DATE OF DEATH: 1-23-49

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 21. N. Decker Ave,

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 21. N. Decker Ave 6-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	MARRIED	MAY 12, 1898	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOHN HELFRICH

14. MOTHER'S MAIDEN NAME: MARGARET EARHART

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: THOMAS E. WILLIAMS, ADDRESS: 21 N. Decker Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 20 Hrs.

DUE TO

(B) Arteriosclerotic Heart Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Secondary Anemia

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/31/48 *to* 1/23/49, *that I last saw the deceased alive on* 1/23/49, *and that death occurred at* 6 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Matthew F. Tenderenda M. D.

23B. ADDRESS: 1816 E Eager Ave

23C. DATE SIGNED: 1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-26-49

24C. NAME OF CEMETERY OR CREMATORY: SACRED HEART

24D. LOCATION (City, town, or county) (State): BALTIMORE Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John A. Moran ADDRESS:

937

VS 150

G70895

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4222 G70895

Registered No.

1. NAME OF DECEASED (Type or Print): Edward T. Clifford

2. DATE OF DEATH: 1-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: BALTIMORE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 703 E. Arlington, Ave.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 703 E. ARLINGTON, Ave. 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W	Single	March 30, 1871	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Maryland	

13. FATHER'S NAME: Thomas E. Clifford

14. MOTHER'S MAIDEN NAME: Anna R. McGargle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Thomas D. Clifford, 719 E. Arlington Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

(B) Chronic Myocarditis — 5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January, 1949 *to* January 21, 1949, *that I last saw the deceased alive on* Jan. 19, 1949, *and that death occurred at* 7:a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas F. Wentz M. D.	3809 Greenmount Ave	1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	1-28-49	New Cathedral	Baltimore	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JAN 25 1949	Huntington Williams, M.D.	John A. Moran

VS 150

937

G70896 ✓260 G70896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Wilma Rebecca Muir or Berry

2. DATE OF DEATH: Jan - 25 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Lafayette & John St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. Women Maryland

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland (222 Spring Ct.) B. COUNTY Balto City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 222 Spring Court - 31 3-A 1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	white	married	May 11 1921	27	8		14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	LONACONING MD	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOSEPH Not Known	CARY LEE METZ Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO —	—	Harold Muir	222 Spring Court - 31 - Baltimore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Diabetic Coma	15 hrs
DUE TO (B)	Diabetes Mellitus	2½ yrs
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan - 24, 1949, *to* Jan - 25, 19 49 *that I last saw the deceased alive on* Jan - 25, 19 49, *and that death occurred at* 1 05 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George M. Schlossnagle M. D.	Hosp. Women Md.	1. 25. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 27/1949	Allegany Cemetery	Frostburg Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams, M.D.	Frank Della Luca	322 S High St

VS 150

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G70897 ✓ 180 G70897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDNA Ruth BRADBURN

2. DATE OF DEATH 1/23/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1022 Riverside

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1022 Riverside Ave 27 3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Married	Aug 11, 1895	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Home	Maryland	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard Hall	Susan E. Bredden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—	—	—	Howard Bradburn	1022 Riverside

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Malignancy of Kidney	14 months
DUE TO (B)	with Metastases	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)	Chronic Cardiac Disease	14 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
April 1948	Malignancy of Kidney	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1946 *to* Jan, 1949 *that I last saw the deceased alive on* Jan 23, 1949, *and that death occurred at* 8:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter Lohr M. D.	102 E. Fort Ave	1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/26/49	Meadowridge Mem.	Washington Blvd Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 26 1949	Huntington Williams, MD	John F. Denny, Inc.

VS 150

52a

G70898 ✓ 331 G70898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Christina Buragino

2. DATE OF DEATH: January 24 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3523 Claremont St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
3523 Claremont St. Baltimore Md. 26 08
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore Md.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	October 5 1895	53	3	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Palermo Sicily Italy	

13. FATHER'S NAME: Antonio Vassallo

14. MOTHER'S MAIDEN NAME: Giuseppina Vassallo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	no		Catherine Vlachos	242. S. Conkling St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Arteriosclerosis
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Cerebral Hemorrhage
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 months

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	—	Baltimore Md

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Dec 4, 1948 *to* Jan 24, 1949, *that I last saw the deceased alive on* Jan 24, 1949, *and that death occurred at* 6.45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE OF M. D.	23B. ADDRESS	23C. DATE SIGNED
H. E. Shrade	11 E Chase	Jan 22 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	January 27/49	Holy Redeemer	Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	Frank Della Rose	222 S. High St.

VS 150

853a

G70899 ✓ 422.1 #43 G70899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Barbara M Wagner

2. DATE OF DEATH: Jan 23-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1310 Inverness Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-5

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1310 Inverness Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widow	July 8 1866	82	6	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Austria - Hungary	

13. FATHER'S NAME: John Heinrich

14. MOTHER'S MAIDEN NAME: Emma Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		None	Mrs. N Cole	Richmond Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Hypertension — ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral Haemorrhage — 11/01/48

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 25, 19[illegible], *to* Jan 17, 1949 *that I last saw the deceased alive on* Jan 19, 1949, *and that death occurred at* 2.30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Carl Rosberg M. D.	1325 W Lombard St	1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/27/49	Dunbar Cemetery	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	Wm Col Inc	1217 E Fond St

VS 150

937

C 70900 ✓ H16 C 70900

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sarah I. Seth

2. DATE OF DEATH Jan 24 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION. (If not in hospital or institution, give street address or location) 1418 Riverside Ave

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1418 Riverside Ave 24-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	5-3-1884	64	8	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Tusconey Pa	U. S. A.

13. FATHER'S NAME Wm H. Button

14. MOTHER'S MAIDEN NAME Angeline McCann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Mrs S. Paul 5649 Dragon Ave. ADDRESS Arbutus

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic heart disease — INTERVAL BETWEEN ONSET AND DEATH: abt 30 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rheumatic fever.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March, 1947, *to* Jan., 1949 *that I last saw the deceased alive on* Jan 19, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1214 N. Chest St.	25 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-27-1949	Cedar Hill	L. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St

VS 150

596

G-0901 ✓442 G-0901

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM HENRY PIPPIN
2. DATE OF DEATH: Jan. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5038 Redman Ave.

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	W	Wid.	Nov. 6, 1868	80	2	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None-Retired	Construction Engineer	Ill.	USA

13. FATHER'S NAME: John Pippin
14. MOTHER'S MAIDEN NAME: Sarah Ellen Mathias

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	WWI- USA	?	Records-	US Marine Hospital, Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) 1- Nephrosclerosis with cardiac hypertrophy	Unknown
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ~~DUE TO~~ DUE TO	(B) 2- Uremia	Unknown
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
Jan. 17, 1949	Single calculus in bladder	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
–		

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Dec. 24, 1948, *to* Jan. 25, 1949 *that I last saw the deceased alive on* Jan. 25, 1949 *and that death occurred at* 10:45 AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Sr. Surgeon Clinical Director M. D.	US Marine Hospital, Balto, Md.	1/25/49

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	1-28-1949	National	Arlington Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	Wm Cook Inc.	127 St. Paul St.

VS 150

131a

C70902 ✓592 C70902

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): CATHERINE HEROLD	2. DATE OF DEATH: Jan. 23. 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 408 S. East Ave.	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
c. Length of stay in Baltimore: life (Yrs. Mos. Days)	D. STREET ADDRESS (If rural, give location): 408 S. East Ave. 2 6 11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	Feb. 2. 1903	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	- - -	Baltimore Md	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Herold	Katherine M. Blessing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
no	none	Mr. George Herold 408 S. East Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Chr. Nephritis	?
DUE TO	complicated by uremia	24 hrs.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO	Chr. arteriosclerosis	?
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 20, 1949 *to* Jan 23, 1949 *that I last saw the deceased alive on* Jan 22 1949, *and that death occurred at* 2:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
N. J. Davidow M. D.	3218 Eastern ave	1-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 28. 1949	Baltimore Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 26 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC. Baltimore Md.

VS 150

131a

G70903 ✓ X 929.8 1990 G70903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Graver

2. DATE OF DEATH: 1/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Found drowned Pier #8, lower Canton
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New Jersey
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Camden
D. STREET ADDRESS (If rural, give location): 629 Bailey St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 8/19/1903
9. AGE (In years last birthday): 45 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seaman
10B. KIND OF BUSINESS OR INDUSTRY: S.S. Herman F. Rasch
11. BIRTHPLACE (State or foreign country): Phila. Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Adam Graver
14. MOTHER'S MAIDEN NAME: Sadie Dawson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Walter Graver, 629 Bailey St., N. J. ADDRESS: Camden

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Drowning
66666

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Acute Alcoholism
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Found drowned Pier #8, lower Canton
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 20 49 2:30A
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fell Overboard into water 16-06

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L Bowen M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/26/49
24C. NAME OF CEMETERY OR CREMATORY: Hillside Phila Pa
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JAN 26 1949
REGISTRAR'S SIGNATURE: Huntington for Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc ADDRESS: 1212 St Paul St.

VS 151

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G70904 ✓ 175 G70904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RAYE RESNICK

2. DATE OF DEATH 1-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO. GEN. HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 15 No Chester St 603

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married		40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		England	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Abraham	Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Morris Resnick 15 No Chester St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) OVARIAN CARCINOMA

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/25/49	GENERALIZED CARCINOMATOSIS	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/24/, 1949 to 1/25/, 1949 that I last saw the deceased alive on 1/25/, 1949 and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. H. Golombek M. D.	West Balto Gen Hosp	1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-26-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

49a

G70905 ✓ 334 G70905

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William J. Jones
2. DATE OF DEATH: Jan 23 - 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 144 N. East Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 144 N. East Ave 6 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	May 15 1866	82	8	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Balto.	U.S.A.

13. FATHER'S NAME: John Jones
14. MOTHER'S MAIDEN NAME: Mary Painter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	None	Anna M. Foll	144 N. East Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	ACTEROSCLEROSIS	13 Yrs
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	HEMIPLEGIA - (RT)	13 Yrs
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CEREBRAL HEMORRHAGE	13 Yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-1, 1946, *to* 1-23, 1949, *that I last saw the deceased alive on* 1-23, 1949, *and that death occurred at* 4:05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James F. Cavanaugh M.D. M. D.	301 W. McCulloh St	1-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JAN 26 1949	OAK LAWN	EASTERN AVE MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	Diffel Bros	1800 E Lombard St.

VS 150

83a

G70906 ✓ H 22.1 G70906

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mary Vollbracht

2. DATE OF DEATH: 24 Jan. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore B. COUNTY: Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 3107 Tyndale Ave 27-01

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3107 Tyndale Ave

c. Length of stay in Baltimore: Yrs. Life Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	April 12, 1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	At Home	Baltimore	U.S.

13. FATHER'S NAME: August Klages

14. MOTHER'S MAIDEN NAME: Caroline Spatz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	No ne	Mrs. Schlomann	7111 Harford Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Wm. H. Kammer, Jr. M.D.		25 Jan. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 27, 1949	Western	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	Rita Wiedefeld	900 E. Riddle St

VS 151

93

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G70907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.H-90817 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Betty Felder

2. DATE OF DEATH: Jan. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-33
D. STREET ADDRESS (If rural, give location) 2618 Pitcpont St

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored		10-7-47	1	15			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Willie Thorne

14. MOTHER'S MAIDEN NAME: Beddies Felder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) ? LEUKEMIA	
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	ACUTE HEART FAILURE	1 day

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/24, 19 49, *to* 1/25, 19 49, *that I last saw the deceased alive on* 1/25, 19 49, *and that death occurred at* 6:25 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Helen C. Mermann M. D.	JOHNS HOPKINS HOSPITAL	1-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/28/49	Mt Auburn Cem	Balto City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Washington Williams M.D.	Isaiah L. Brown & Son	108 W Montgomery St

VS 150

74a

G70908 ✓ 762.0 G70908

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C. 48-25092

1. NAME OF DECEASED (Type or Print): EUGENE YOUNG

2. DATE OF DEATH: January 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 911 Myrtle Avenue

C. Length of stay in Baltimore: 2 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 911 Myrtle Avenue 17-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	colored	—	11-13-1948		2			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	—	Balto. Md.	

13. FATHER'S NAME: Nathaniel Bell.

14. MOTHER'S MAIDEN NAME: Joyce Young.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Joyce Young.	911 Myrtle Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Suffocation due to aspiration of vomitus.

(B) Partial atelectasis of lungs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		January 25, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/26/49	Mt. Auburn Cem.	Balto.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	Mrs Kate K. Williams	322 N. Gilmor St

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161a

G70903 ✓ E 840,0 G70903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1403

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rose McKee

2. DATE OF DEATH: 1/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: 59 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1814 N. Broadway St. 8 0 5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
F	W	Single	--------	69	-	-	-	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Henry McKee

14. MOTHER'S MAIDEN NAME: Sarah --Fox--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Lillian Suding ADDRESS: 4301 ..olard ..v

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull =
DUE TO
(B) Intracranial Hemorrhage
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Crossing North Ave. at Broadway going North to board car.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 23 49 7:15 P.m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR?: Pedestrian struck by streetcar 8 0 5

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Emil Beyer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/27/49

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 26 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: H. W. Meeks and Son ADDRESS: 805 N. Calvert St.

VS 151

1710

BX 125644 G70910 ✓ 331 G70910

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Williams

2. DATE OF DEATH: 1- 18- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 40 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 264 Robert ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	C	Sep.	May 26- 1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Del.	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Alice ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Records Balto. City Hospitals	4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 3 WEEKS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) HYPERTENSION — ?

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
NONE		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NONE		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12 - 28, 1948 *to* 1- 18 -, 1949 *that I last saw the deceased alive on* 1- 18 -, 1949 *and that death occurred at* 10:05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T Lennox R. Jernigan M. D.	BALTIMORE CITY HOSPITALS	1-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	1/29/49	Mt Calvary	Cedar Hill -

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	A Hartlead	918 Dundalk

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (First, Middle, Last): Cora Purnell Thomas
2. DATE OF DEATH: 1/23/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Yes.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 528-Johnson St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
c. Length of stay in Baltimore: 25 Yrs. — Mos. — Days
D. STREET ADDRESS (If rural, give location): 528-Johnson St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
F.	Col.	Widow	Feb. 2 1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed		Va.	U.S.A.

13. FATHER'S NAME: Charles Henry Easley
14. MOTHER'S MAIDEN NAME: Ella Easley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give branch and dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Margaret Johnson	537-

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 mos
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-22-, 1949 *to* 1-23, 1949 *that I last saw the deceased alive on* 1-22, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W Atwell Parker M. D.	5-3-4 Rolfe St	1-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town or County) (State)
Burial	1/29/49	Mt Calvary	Cedar Hill Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	A Halstead	812 David Hill

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Duvall

2. DATE OF DEATH: 1-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

C. Length of stay in Baltimore: 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 7523 Carroll Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Aug. 16, 1882	66 65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pump operator		Maryland	U.S.

13. FATHER'S NAME: Thomas Duvall

14. MOTHER'S MAIDEN NAME: Mary Hadel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Hospital records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Uremia	5 days
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Carcinoma of Bladder	2 mos
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-3-49	Papillary carcinoma of bladder	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-27, 1949, *to* 1-24, 1949, *that I last saw the deceased alive on* 1-24, 1949, *and that death occurred at* 10:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard M. Garrett M.D.	Church Home & Hosp	25 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) — (State)
Burial	1-28-49	Oaklawn	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington for Williams, M.D.	Ellsworth Annacost	526

VS 150

3911 Liberty Heights Ave

G7091.3 ✓ 422.1 G7091.3

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ISAAC SHIPP — 2. DATE OF DEATH: January 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 637 West Fayette Street 4-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
male	white	W	July 13-1876	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNKNOWN	?	North Carolina	USA

13. FATHER'S NAME: JOHN SHIPP
14. MOTHER'S MAIDEN NAME: JANE ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
NO	—	—	MRS. V. SMITH	2810 RAYNOR AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteria - Sclerotic

DUE TO

(B) Cardio - vascular Disease -

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C DATE SIGNED
Earl L Kaye M.D.		Jan. 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	1/27	Loudon Park	Balto.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
VS JAN 26 1949	Courtesy for Williams, M.D.	John T. Stansbury	2700 Edmondson Ave. 93D

E904.5

BIRTH NO. 570914

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

N803. Registered No. 050914

1. NAME OF DECEASED (Type or Print): Charles Nitz

2. DATE OF DEATH: 1/9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1500 N. Fulton Ave. 1502

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	W	7/28/1899	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Nitz
14. MOTHER'S MAIDEN NAME: Mamie Frandom
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: 215-10-3609
17. INFORMANT: Wm Nitz ADDRESS: 109 N. Mitchell Ave Stanton Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of skull
(B) Intracranial hemorrhage
(C) Contusion of brain

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Found on areaway-2000 block Pennsylvania Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 9 49 5 A m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Probably fell to ground 1405

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *and from* Autopsy *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill, M.D. per [signature] M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/26/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park.
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John T. Shanahan ADDRESS: 2700 Edmondson Ave. 186a

VS 151

G70915 ✓ X 610 G70915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Fred Schumacher

2. DATE OF DEATH: 1/25/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore Gen'l. Hosp.

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): Miller's Station, Carroll Co. Md

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	12/10/1879	69 71	1 / 15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MECH. ENGINEER	MACHINE SHOP	Maryland	

13. FATHER'S NAME: Frederick Schumacher

14. MOTHER'S MAIDEN NAME: Mary Arbin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		J SCHUMACHER 41 BURKE AVE Tow.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritonitis, Purulent — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Urinary Extravasation — 4 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Arteriosclerosis, Generalized

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bacillic Bronchogenic Carcinoma

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-20-49 / 1-24-49	Enlarged Prostate / Urinary Extravasation	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 15 Jan, 1949 *to* 25 Jan, 1949, *that I last saw the deceased alive on* 25 Jan, 1949, *and that death occurred at* 12 30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allan E. Grewashis M. D.	S. Balto. Gen. Hosp.	25 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	1-28-49	PARKWOOD	BAL. TO. COUNTY

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JAN 26 1949	Evelyn Williams, M.D.	H. W. JENKINS & SONS Co. 4905 YORK RD

MS 150

137a

✓ 170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C70916 · Registered No. C70916

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henrietta Steuart

2. DATE OF DEATH: Jan 28th / 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1035 St Paul St.

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1035 St Paul St 11-21

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Wh.	Single	17 July 1873	75	6	8 / ✓ / ✓

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Balto Md	USA.

13. FATHER'S NAME: Dr James N. Steuart

14. MOTHER'S MAIDEN NAME: Ellen L Duvall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Jas E. Steuart — ADDRESS: 1035 St Paul St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast with metastasis.

DUE TO

(B) —

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6. 14. 1948 *to* 1. 24. 1949 *that I last saw the deceased alive on* 1. 24. 1949 *and that death occurred at* 3 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm J. Faulw M. D.	11 E. Chase Street	1. 25. 49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 27 1949	Green Mount	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Remitting for Williams, M.D.	Henry W. Jenkins & Son Co	4925 York Rd.

50

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Thomas C. Grim

2. DATE OF DEATH: Jan. 24th 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital

c. Length of stay in Baltimore: Yrs. 6 Mos. 9 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3323 Brighton St.,

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	W	Married	Jan. 6, 1881	68 69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Paymaster		Baltimore, Md.	

13. FATHER'S NAME: Thomas Grim

14. MOTHER'S MAIDEN NAME: Emma Kaufman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	212-07-5449	Mrs. Edna A. Grim	3323 Brighton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Arteriosclerotic CVD — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Unknown

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 24, 1949 *to* Jan. 24, 1949, *that I last saw the deceased alive on* Jan. 24, 1949, *and that death occurred at* 8:20 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Kathryne V. Kemp M. D.	West Baltimore General Hosp.	Jan 24th '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	1-27-49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Thurlington Williams, M.D.	G. Howard Strong	3207 W. North Ave

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM LAING WINTERTON
2. DATE OF DEATH: 1-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital Balto Md.
C. Length of stay in Baltimore: 10 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Near Towson
D. STREET ADDRESS (If rural, give location) 1 Old Court Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M.	W.	Single	1-14-49		—	10	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William B. Winterton
14. MOTHER'S MAIDEN NAME: Merta Laing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO —
17. INFORMANT: Patients Chart in Hospital ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(B) Congenital atresia Pylorus
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-14 1949, *to* 1-25, 1949, *that I last saw the deceased alive on* 1-25, 1949, *and that death occurred at* 3:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Arthur M. Bacon Jr. M. D. — 23B. ADDRESS Mercy Hospital. Balto Md — 23C. DATE SIGNED 1-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify) 1-26-49. — 24B. DATE 1-26-49. — 24C. NAME OF CEMETERY OR CREMATORY CATHEDRAL. — 24D. LOCATION (City, town, or county) (State) CITY

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR ADDRESS WIEDEFELD & SON.

JAN 26 1949

GREENMOUNT 1 22 NA
157G

BIRTH NO. 67093

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 422.2 67093

1. NAME OF DECEASED (Type or Print): Hilda Johnson
2. DATE OF DEATH: 1/24/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 553 N. Lafayette Ave. 17-01
5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1/5/13
9. AGE (In years last birthday): 36 — If Under 1 Year: Months, Days: 19 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Trenton, N.J.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Herman Thompson
14. MOTHER'S MAIDEN NAME: Cora Rawlings
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Robt. Johnson ADDRESS: 533 N. Lafayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Myocardial degeneration

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

over

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [✓] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Druid Hill & Biddle 17-01
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 19 49 4:40 Pm.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Thrown from funeral car

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [✓], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Emil L. Apfe M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/29/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): A. R. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949
REGISTRAR'S SIGNATURE: Livingston Williams, M.D.
25. FUNERAL DIRECTOR AND ADDRESS: W.H. JACKSON 916 Penna. Ave.

VS 151

93D

G70920

BALTIMORE CITY HEALTH DEPARTMENT 443 G70920

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): IRENE GARDNER

2. DATE OF DEATH: Jan. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Meth. Home for the Aged
2211 W. Rogers Ave.

C. Length of stay in Baltimore: 62 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 W. Rogers Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	Sept. 19, 1865	83 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chestertown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Benjamin Hamilton Gardner

14. MOTHER'S MAIDEN NAME: Sarah Catherine Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): -

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Miriam O. Coates ADDRESS: 2211 W. Rogers Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-vascular disease
DUE TO: & hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C) Intestinal obstruction

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Advanced arthritis deformans

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 22, 1949 *to* Jan 25, 1949 *that I last saw the deceased alive on* Jan 24, 1949, *and that death occurred at* 6:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Charles L. Warner M. D.

23B. ADDRESS: 421 Med. Arts Bldg

23C. DATE SIGNED: 1 25 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/27/49

24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.

24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 26 1949

REGISTRAR'S SIGNATURE: Hunting for Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

93D

G70921 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

151 Registered No. G70921

1. NAME OF DECEASED (Type or Print): PIETRO G. PROFILI

2. DATE OF DEATH: Jan. 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2206 E. Lanvale St.

c. Length of stay in Baltimore: 47 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2206 E. Lanvale St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	Aug. 7, 1895	53 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor	Self	Italy	

13. FATHER'S NAME: Dominic Profili

14. MOTHER'S MAIDEN NAME: -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	none	Mr. Gene Profili	2206 E. Lanvale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the stomach

DUE TO Peptic ulcer on lesser curvature of the stomach

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 8 months

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
December 2, 1948	Carcinoma of stomach; extensive metastasis throughout abdomen and liver	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 14, 1948 *to* January 24, 1949, *that I last saw the deceased alive on* Jan. 24, 1949, *and that death occurred at* 6:25p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philibert Antegiani M. D.	2942 E. Fayette Street	1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/28/49	Holy Redeemer Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
	Hunting for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

JAN 26 1949

462

70922 ✓ 002 70922

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM BRAYTON MANN

2. DATE OF DEATH: Jan. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 529 E. 20th St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 529 E. 20th St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
male	white		Nov. 17, 1887	61 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	Wm. B. Mann, Sr.	Baltimore, Md.	

13. FATHER'S NAME: William B. Mann, Sr.

14. MOTHER'S MAIDEN NAME: Carrie M. Grace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no			Mrs. Rose F. Mann	529 E. 20th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — Interval between onset and death: Unknown

DUE TO Left Upper Lobe

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☐ NO ✓

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 17, 1949, *to* Jan 24, 1949, *that I last saw the deceased alive on* Jan 24, 1949, *and that death occurred at* 11 45 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James E White M. D.	5214 Harford Road	Jan 26 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/28/49	Greenmount Cem	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Theodore Jos Williams, M.D.	WILLIAM J. TICKNER & SONS	Balto., Md.

VS 150

136

✓ 422.1

G70923 **BALTIMORE CITY HEALTH DEPARTMENT** G70923

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Harry Thompson

2. DATE OF DEATH 1/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital
C. Length of stay in Baltimore — Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 308 N. Gilmor St. 19-41

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C		1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME Wm. Thompson

14. MOTHER'S MAIDEN NAME Susie Lane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Lillian E. Clark 2024 Divison St.

MEDICAL CERTIFICATION

16. **CAUSE OF DEATH**

		INTERVAL BETWEEN ONSET AND DEATH
I **DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic Cardiovascular Disease	
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.	(B)	
	DUE TO	
	(C)	
II **OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
Carl L Boyer			1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/29/49	Mt. Auburn	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	Geo. C. Nelson	1903 Pressman St.

VS 151

929

✓ H20.1 G70924

G70924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George Emory Fulton Thomas

2. DATE OF DEATH January 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 326 N. Mount St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 326 N. Mount Street
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 326 N. Mount Street 19 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	MARRIED	May 9, 1872	76	9	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Ann Arundel County, Md	America

13. FATHER'S NAME: Richard Thomas

14. MOTHER'S MAIDEN NAME: Julian Rebecca Henson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	220-07-5588	Gertrude Smith	326 N. Mount St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Occlusion	2 Days
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Hypertensive Heart Disease	Several Mos.
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 2, 1948 *to* Jan. 27, 1949, *that I last saw the deceased alive on* Jan. 27, 1949, *and that death occurred at* 4:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard H. Hunt M. D.	1631 W. Franklin Street	Jan. 25 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/27/49	Mt Auburn	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	Wes. H. Nelson	1303 Pennsylvania Ave

VS 150

93

592 G70925

G70925

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William W. Wieson (WILSON)

2. DATE OF DEATH: January 23 49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 2129 E Preston St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE — B. COUNTY: 2129 E Preston

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): None

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 2129 E Preston St 8-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	June 25 1884	64	6	30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Service

10B. KIND OF BUSINESS OR INDUSTRY: General Bakery

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Upton Wieson

14. MOTHER'S MAIDEN NAME: Julia Lee Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Julia M Wieson 2129 E Preston

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Uterine Sarcoma + Hypertension — 17 days

DUE TO

(C) Chronic Interstitial Nephritis — 17 d

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 6 19 49, *to* June 23 19 49, *that I last saw the deceased alive on* Jan 23 19 49 *and that death occurred at* 3 15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. P. A. Stevens M. D.

23B. ADDRESS: 2878 Harford Rd

23C. DATE SIGNED: 1-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/27/49

24C. NAME OF CEMETERY OR CREMATORY: London Park

24D. LOCATION (City, town, or county) (State): Frederick Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 26 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR — ADDRESS: Clarence F. Hoffmann 1639 Broadway.

VS 150

131a

✓ 420.1

G70926

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70926
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRY A DAVIS

2. DATE OF DEATH: 1-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Mercy Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
D. STREET ADDRESS (If rural, give location): 7 E. Cager St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	W	May 2, 1899	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Passenger Train Inspector
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Davis
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Abe Weinstein ADDRESS: 4337 Forest Park Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ventricular standstill — INTERVAL BETWEEN ONSET AND DEATH: Immediate

DUE TO

(B) Heart block; Coronary Thrombosis — Unknown

DUE TO

(C) Hypertension and Arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 18, 1949 *to* Jan 23, 1949, *that I last saw the deceased alive on* Jan 22, 1949, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John R Buchanan M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 27/49
24C. NAME OF CEMETERY OR CREMATORY: Helen Washington Rd
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR / ADDRESS: Levinson Bros, 1124 W. North Ave.

VS 150

937

G70927 ✓ 241 G70927

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) JOHN H. MYERS

2. DATE OF DEATH 1/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO. GEN. HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 620 N. Dean St 76 09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		7-15-1888	60	6 9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) New York N. Y.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James H. Myers
14. MOTHER'S MAIDEN NAME Coral Bell Happ
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-09-5416
17. INFORMANT Mrs Myrtle Myers-620 N Dean St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) COR PULMONALE
DUE TO
(B) CHRONIC ASTHMA
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/24/ 1949 to 1/24/ 1949 that I last saw the deceased alive on 1/24/ 1949 and that death occurred at 10:30 PM from the causes and on the date stated above.

23A. SIGNATURE I B Solomon M. D.
23B. ADDRESS West Balto Gen Hosp
23C. DATE SIGNED 1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1-28-49
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem
24D. LOCATION (City, town, or county) Eastern Ave - Balto Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR JAN 26 1949
REGISTRAR'S SIGNATURE Huntington for Williams, M.D.
25. FUNERAL DIRECTOR John C. Miller Inc
ADDRESS 2435 E. Oliver St

VS 150

112

G70928 ✓ X G70928

BALTIMORE CITY HEALTH DEPARTMENT 445

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. Herbert

1. NAME OF DECEASED (Type or Print) EARL HECKART

2. DATE OF DEATH 1-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) W. Balto. Gen'l. Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3047 Parktowne Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	MARRIED	Aug 18-1912	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Bakery	PA.	U.S.A.

13. FATHER'S NAME Charles A. Heckart

14. MOTHER'S MAIDEN NAME Mae R. Mc Cleary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 195-07-6117

17. INFORMANT Mrs. Anna Heckart - Parktowne ADDRESS 3047

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiorespiratory failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Chronic Brights Disease

DUE TO

(C) Malignant Hypertension — 10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Generalized Arteriosclerosis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-7, 1949 *to* 1-25, 1949 *that I last saw the deceased alive on* 1-25, 1949 *and that death occurred at* 10:55 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lida C. Brown M.D.	W. Balto. Gen'l Hosp.	1-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-28-49	Shoops Cem.	Dauphin Co, Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	L. J. Ruck	5305 Harford Rd.

121a

G70929 ✓ 4411 G70929

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ~~Frederick~~ Frederick W. Wolf

2. DATE OF DEATH 1-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Franklin Sq. Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) alone. Franklin Sq. Hosp.

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md.

D. STREET ADDRESS (If rural, give location) 413 E. Gittings St 24-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		11-22-1908	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ship joiner	US Coast Guard Depot	Baltimore, Md.	U.S.

13. FATHER'S NAME Frederick L. Wolf

14. MOTHER'S MAIDEN NAME Eva R. Guyton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	------	------	Mrs. Eva A. Wolf (Mother)	413 E. Gittings St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Renal

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Malignant Hypertension

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-10-49, 1949 *to* 1-25-, 1949 *that I last saw the deceased alive on* 1-25, 1949, *and that death occurred at* 4 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. J. Finkell M. D.	Franklin Sq. Hospital	1-25-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sat. Jan. 29, 1949	Western Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	C. Howard Evans	1400 S. Charles St Balto 30 Md.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. B.C. 49-03751

1. NAME OF DECEASED (Type or Print): Gloria Aldridge

2. DATE OF DEATH: January 25th. 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 538 Wilson Street
c. Length of stay in Baltimore: 3 Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 538 Wilson Street 14-07

5. SEX: F
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan. 23rd. 1949
9. AGE (In years last birthday): - If Under 1 Year: Months: Days: 3 If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Aldridge
14. MOTHER'S MAIDEN NAME: Mary White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: John Aldridge ADDRESS: 538 Wilson Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 36 hr.
DUE TO
(B) Possible Congenital H.D.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. Garland Spinell M. D.
23B. ADDRESS: 902 W. Franklin
23C. DATE SIGNED: 1-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 26th. 49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Westport (Baltimore)

DATE RECEIVED BY LOCAL REGISTRAR: JAN 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph L. Russ
ADDRESS: 1200 McCulloh Street

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John W. Monroe

2. DATE OF DEATH: Jan. 24th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1716 W. Lombard St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1716 W. Lombard St 2-0-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	7-8-1884	64	6	16		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Pipe-fitter	Va	U.S.A.

13. FATHER'S NAME: J. Monroe

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-01-3242

17. INFORMANT: Mrs. Mary E. Wagner ADDRESS: 514 Parkside Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

(B) Chronic Myocarditis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 8 1947 *to* Jan 24 1949, *that I last saw the deceased alive on* Jan 2 1949, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Albert Scagnetti M. D.

23B. ADDRESS: 1724 W Lombard St

23C. DATE SIGNED: Jan 25 '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-27-1949

24C. NAME OF CEMETERY OR CREMATORY: Maryland Park

24D. LOCATION (City, town, or county) (State): Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 26 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Wm Cook Inc. 1217 St. Paul St.

VS 150

937

G70932 ✓ 332 G70932

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES R. COLSTON

2. DATE OF DEATH: Jan. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2610 Elsinor Ave.
c. Length of stay in Baltimore: Yrs. 15 Mos. 3 Days 8

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2610 Elsinor Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
male	white	married	June 27, 1859	89 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ins. Agt.	Jacob Gross, Jr. Inc	Md.	

13. FATHER'S NAME: Joseph H. Colston

14. MOTHER'S MAIDEN NAME: Catherine Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no	Mr. William W. Bandell	2565 W. Balto. St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Senility; Arteriosclerosis — Beyond 1 yr.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 17, 1947, *to* June 25, 1949, *that I last saw the deceased alive on* June 24, 1949, *and that death occurred at* 2:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Maurice F. Thomas M. D.	3307 W. North Ave (16)	Jan. 25 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	1/27/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

83B

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BALTIMORE CITY HEALTH DEPARTMENT 4-29-1

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Godfrey Peppler

2. DATE OF DEATH: 1-25-49 6.50 P.M.

3. PLACE OF DEATH: A. Baltimore City, Maryland — St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Md. B. COUNTY: C. CITY OR TOWN: Balto.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caton & Wilkens ave.

D. STREET ADDRESS (If rural, give location): 1814 N. Chester St.

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M.	W.	widowed	10-27-1903	45 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	

13. FATHER'S NAME: Charles E. Peppler

14. MOTHER'S MAIDEN NAME: Margaret Lorz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Mr. Louis A. Peppler	1814 N. ChesterSt

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO (B) & ventricular septum & cardiac tamponade

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Coronary sclerosis TAMPONADE

DUE TO (C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-19 1949 *to* 1-25, 1949 *that I last saw the deceased alive on* 1-25, 1949, *and that death occurred at* 6.50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sidney Johnson Venable Jr M.D.	St. Agnes Hospital	1-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/28/49	Parkwood	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 26 1949 VS 150	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

94a

✓ 161

G70934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70934

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. John RALPH SLUNT

2. DATE OF DEATH: 25 January 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3440 Roland Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	W	widowed	Sept. 28, 1885	63 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	W. Md. R. R.	Baltimore, Md.	

13. FATHER'S NAME: Charles Slunt

14. MOTHER'S MAIDEN NAME: Katherine Coffee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	219-01-9071	Mrs. Hazel Christopher	307 Warren Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of larynx

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
January 13, 1949	Gastrostomy	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/12 1949 *to* 1/25 1949 *that I last saw the deceased alive on* 1/25 1949, *and that death occurred at* 4 25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph Robert Liberto M. D.	Bon Secours Hosp	1/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/28/49	New Cathedral Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams, M.D.	WILLIAM J. TICKNER & SONS	Balto., Md.

VS 150

47a

BALTIMORE CITY HEALTH DEPARTMENT ✓ 490

CERTIFICATE OF DEATH

Registered No. C#20935

BIRTH NO. C#20935

1. NAME OF DECEASED (Type or Print): PAM NEEDHAM

2. DATE OF DEATH: January 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1324 Eutaw Place

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1324 Eutaw Place 11-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widowed	approx. 1884	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Melford, Delaware

12. CITIZEN OF WHAT COUNTRY? U.S. ✓

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT ADDRESS: Capt. Ralph C. Needham, U.S.N, University of S. Carolina

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) [illegible] Pneumonia

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20 AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: Carl L. Pugh M.D.

23B CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: January 26, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
cremation	Jan. 27, 1949	Fort Lincoln Cemetery	Prince George County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 26 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: John M. Taylor, Annapolis, Maryland

VS 151

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G70936 ✓ E902.3 N803 G70936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD (MARTIN) MAUPIN

2. DATE OF DEATH: January 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 625 S. Bunly Street 2-6-9

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	8/21/1912	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel Erector

10B. KIND OF BUSINESS OR INDUSTRY: Beth. Steel Co.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edward F. Maupin

14. MOTHER'S MAIDEN NAME: Margaret Eddins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT: Mae Wood Maupin ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull.

DUE TO Intracranial hemorhage.

DUE TO Contusion of brain.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Shipyard--Industrial

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Bethlehem Steel Shipyard--Sparrows Pt

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 25, 1949 p.m.

21E. INJURY OCCURRED: WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? Knocked 45' into hold of ship

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 28. 1949

24C. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem

24D. LOCATION (City, town, or county) (State): Fox Union Va.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 27 1949

REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.

25. FUNERAL DIRECTOR: Roland L Yoder ADDRESS: 2112 Sundale Rd 172 Sundale Md.

VS 151

G70937 ✓x 420.1 G70937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN VAN BUSKIRK

2. DATE OF DEATH: Jan. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: 13 days (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Ohio
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashtabula
D. STREET ADDRESS (If rural, give location): 1409 W. Third St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	W	Married	Apr. 14, 1880	68	9 / 11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Captain	Seafarer	Michigan	USA

13. FATHER'S NAME: James Van Buskirk

14. MOTHER'S MAIDEN NAME: Margaret White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
Unknown	276-16-3224	Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary sclerosis with occlusion	
	DUE TO and myocardial infarction	less than 1 week
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Jan. 12, 1949, *to* Jan. 25, 1949, *that I last saw the deceased alive on* Jan. 25, 1949, *and that death occurred at* 1 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David S. LeMaund M. D.	U.S. Marine Hospital	1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1/27/49		Conneaut, Ohio

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JAN 27 1949	Huntington Williams, MD	Wm. J. Tickner & Sons

VS 150

94a

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G70938 (Birth No.) — G70938 (Registered No.)

1. NAME OF DECEASED (Type or Print): Robert. E. DotLard.

2. DATE OF DEATH: Jan. 26 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 2117 Denison St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Crawford Retreat

c. Length of stay in Baltimore: Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5509. Fernbank Ave 28-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Masonic	Nov. 18 1876	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Building Manager	Pa R.R.	Philadelphia Pa	U.S.

13. FATHER'S NAME: Robert E DotLard

14. MOTHER'S MAIDEN NAME: Sara L. Lane White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	716-16-6396	Mrs Dothard	5509. Fernbank Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO

(B) Carcinoma of prostate — 1 yr

DUE TO

(C) Secondary anemia — Terminal

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr Thos F Athol M.D.	1509 Eutaw Pl Balto Md	1-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	Jan. 31 1949	West Laurel Hill	Eynwid, Pa. CYNWID

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	~~Huntington Williams, M.D.~~	J. Willis Lemmerman	415 Light St

51B

AB-92149
G70939

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

Registered No. G70939

1. NAME OF DECEASED (Type or Print): Jacob Wassness

2. DATE OF DEATH: Jan. 23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 53yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 600 W. Baltimore St. 4-2

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug. 17-1865
9. AGE (In years last birthday): 83 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob
14. MOTHER'S MAIDEN NAME: Katie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Baltimore City Hospitals Records- ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) CEREBRAL HEMORRHAGE	5 DAYS
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) GENERALIZED ARTERIOSCLEROSIS	?
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NONE
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-15, 1945 *to* 1-23, 1949, *that I last saw the deceased alive on* 1-23-, 1949 *and that death occurred at* 7 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Thomas P. Jennings, M. D.
23B. ADDRESS: BALTIMORE CITY HOSPITALS
23C. DATE SIGNED: 1-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/27/49
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart
24D. LOCATION (City, town, or county) (State): Lemmon Hill Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John F. Lake & Sons
ADDRESS

VS 150

$3a

✓ X 092

G70940

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70940

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANDREW TRUMPOWER
2. DATE OF DEATH: Jan. 25/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore County
D. STREET ADDRESS (If rural, give location): Gwynn Brook Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		6-28-90	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or Foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Andrew Trumpower	Lucinda Repp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	218-12-4150	JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute hepatic necrosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

(B) ? Infectious hepatitis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/21 19[49], *to* 1/25, 19[49], *that I last saw the deceased alive on* 1/25, 19[49], *and that death occurred at* 2[35] *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William W. Wurbersich M. D.	JOHNS HOPKINS HOSPITAL	1-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 28 1949	St Paul's Cemetery	Clear Spring Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 27 1949	Huntington Williams, M.D.	Wm Berryman & Sons Reisterstown Md

VS 150

125a

CERTIFICATE CORRECTED 2-9-49 ✓ 420.1 G 70941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE CORRECTED 2-16-49 CERTIFICATE OF DEATH Registered No. G 70941

1. NAME OF DECEASED (Type or Print): DAVID Harry Finn
2. DATE OF DEATH: January 25, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1519 Pentridge Rd. 21-9
3B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp. DOA
3C. Length of stay in Baltimore: Yrs. Mos. Days
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 3, 1884
9. AGE (In years last birthday): 64 (84) yrs. If under 1 Year: Months Days; If under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Railway Express Co.
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Patrick Finn
14. MOTHER'S MAIDEN NAME: AugustaPellicott
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Barbara K. Finn ADDRESS: 1519 PentridgeRd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☑, *undetermined* ☐.

23A. SIGNATURE: William J. Helbrick M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 1/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/29/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WILLIAM J. TICKNER & SONS ADDRESS: Balto., Md.

VS 151

94a

G70942 ✓ 420.1 G70942

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO

1. NAME OF DECEASED (Type or Print) REV VERNON NORWOOD RIDGELY — 2. DATE OF DEATH 26 JAN 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 9-2

D. STREET ADDRESS (If rural, give location) 1620 SHADYSIDE ROAD #18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
MALE	WHITE	MARRIED	14 FEB 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MINISTER		HOWARD COUNTY MARYLAND	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WASHINGTON RIDGELY	ELLEN HUTSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
UNKNOWN	none	WIFE Mrs. H. LaRue Ridgely	1620 Shadyside Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	MYOCARDIAL INFARCTION	16 DAYS
DUE TO (B)	CORONARY OCCLUSION	16 DAYS
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY
NONE		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NONE		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 16 JAN, 1949 *to* 26 JAN, 1949, *that I last saw the deceased alive on* 26 JAN, 1949, *and that death occurred at* 10:25A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald F England M.D.	MARYLAND GEN. HOSP.	26 JAN 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/29/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Tentatively for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

94a

G70943 ✓331 G70943

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Annie A Newell
2. DATE OF DEATH: Jan 25, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 445 Illchester Ave
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-2; D. STREET ADDRESS (If rural, give location) 445 Illchester Ave
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 26, 1875
9. AGE (In years last birthday): 73; If under 1 Year: Months 0 Days 29; If under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: John Cavanough
14. MOTHER'S MAIDEN NAME: Not known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
16. SOCIAL SECURITY NO: none
17. INFORMANT: James J. Newell ADDRESS: 445 Illchester Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage Left Internal Capsule — INTERVAL BETWEEN ONSET AND DEATH: 20 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral arteriosclerosis and generalized arteriosclerosis — 20 yrs

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 25, 1949 to Jan 25, 1949, that I last saw the deceased alive on Jan 25, 1949 and that death occurred at ____ m., from the causes and on the date stated above.

23A. SIGNATURE: William R Draughty M. D.
23B. ADDRESS: 10 E Biddle St
23C. DATE SIGNED: Jan 26 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 29, 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town or county) (State): 4300 Old Frederick Rd Balt Md.

DATE RECEIVED BY REGISTRAR: JAN 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elmer W. Conklin ADDRESS: 924 E. Eager St.

VS 150

8-3a

G70944 ✓ 1638 G70944

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Pukaczowski

2. DATE OF DEATH: 1/25/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-1
D. STREET ADDRESS (If rural, give location): 8 N. Decker ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		1-1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor

10B. KIND OF BUSINESS OR INDUSTRY: Samuel Cohn

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Pukaczowski

14. MOTHER'S MAIDEN NAME: Cecelia Wrobell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 217-07-5362

17. INFORMANT: Mary Pukaczowski ADDRESS: 8 N. Decker Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemapericardium — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinomatosis, Type unknown

DUE TO

(C) Bronchopneumonia, terminal

over

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/20, 1949, *to* 1/25, 1949, *that I last saw the deceased alive on* 1/25, 1949, *and that death occurred at* 1:50 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: John R. Shell M. D.

23B. ADDRESS: Mercy Hospital

23C. DATE SIGNED: 1/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 29-1949

24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart

24D. LOCATION (City, town, or county) (State): Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 27 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. S. Fialkowski ADDRESS: 2007 Eastern Ave

VS 150

47C

G70945 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4221 ✓ Registered No. G70945

1. NAME OF DECEASED (Type or Print): John W. T. Lybic

2. DATE OF DEATH: 26 Jan. 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 143 Catherine St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-4
D. STREET ADDRESS (If rural, give location): 143 Catherine St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Day: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widower	May 21, 1876	72	8	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Rest Room	Pa	

13. FATHER'S NAME: Samuel Lybic

14. MOTHER'S MAIDEN NAME: Sarah Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Goldie Foltz	Harrisburg Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-
DUE TO Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Wm. H. Kammer, Jr. M.D.		26 Jan. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Funeral	1/27/49	Union	Duncannon Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Huntington Williams, M.D.	Wilhelm & Sons	1214 St Paul St

VS 151

931

✓ 425.1

G70946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70946

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dora J.Munding

2. DATE OF DEATH: Jan 25 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 408 S.Augusta Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 82 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 408 S.Augusta Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 408 S.Augusta Ave 20-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Mar 24 1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home		Baltimore Md	

13. FATHER'S NAME: Christian F.Reuter

14. MOTHER'S MAIDEN NAME: Genevieve Peters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Ginevra D.Munding	408 S.Augusta Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) arteriosclerotic CVD

DUE TO

(C) hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1948, *to* Jan 24, 1949 *that I last saw the deceased alive on* 1-24, 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Laurance J Hummel M. D.	3711 Dalls Md	1-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 29 1949	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Huntington Williams, M.D.	Harry A Hummel	4204 Ridgewood Ave

VS 150

93D

6709-47 ✓ 331 6709-47

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 4th Return

1. NAME OF DECEASED (Type or Print): GEORGIA BESSIE NEAL

2. DATE OF DEATH: Jan. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1710 Woodyear St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1710 Woodyear St

C. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1710 Woodyear Street 15-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Widow	3/1/1880	68	10	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Housewife	Stemensville, Md.	U.S.A.

13. FATHER'S NAME: James Sewell

14. MOTHER'S MAIDEN NAME: Mary Saunders

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.			Mr. George Neal	1710 Woodyears St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1/23/49

DUE TO

(B) Hypertensive

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/10, 1949 *to* 1/23, 1949 *that I last saw the deceased alive on* 1/18, 19 49, *and that death occurred at* 4:40 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Howell Louis Stuart M. D.	113 Harlem Ave	1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/27/1949	Arbutus Memorial Pk.	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Huntington Williams, MD	Mrs. George H. Holland	1631 Druid Hill Ave.

VS 150

83a

G70948

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 421.4 G70948

Registered No. Holland

1. NAME OF DECEASED (Type or Print): BERTHA P. HARDING

2. DATE OF DEATH: Jan. 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 831 Harlem Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 831 Harlem Ave.

c. Length of stay in Baltimore: 42 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 831 Harlem Ave. 17-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hours: Hours	If Under 24 Hours: Min.
Female	Colored	Widow	Jan. 12, 1885	64	0	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Erie, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Peck

14. MOTHER'S MAIDEN NAME: Etta Bladden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Mr. George B. Harding ADDRESS: 2503 McCulloh St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-20, 1949 *to* 1-25, 1949 *that I last saw the deceased alive on* 1-25, 1949 *and that death occurred at* 7.20 *pm, from the causes and on the date stated above.*

23A. SIGNATURE: Wade L. Wadell M. D.

23B. ADDRESS: 861 Park Ave

23C. DATE SIGNED: 1-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/28/1949

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 27 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Mrs. George H. Holland 1631 Druid Hill Ave.

VS 150

92D

CERTIFICATE CORRECTED 2-9-49 ✓ 704.1

G70949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G70949

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Josephine Reese

2. DATE OF DEATH: 1/26/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 321 E. 22nd St.

c. Length of stay in Baltimore: 59 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 321 E. 22nd St. 12-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Dec. 12, 1889	59	1	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	------	Baltimore, Maryland	

13. FATHER'S NAME: Frank C. Reese

14. MOTHER'S MAIDEN NAME: Annie M. Winters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs. Frank C. Reese	321 E. 22nd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Myocarditis Chronic Interstitial — 2 years
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 1, 1949, *to* Jan. 26, 1949, *that I last saw the deceased alive on* 1/26/, 1949, *and that death occurred at* 10:20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas F. Mertz M. D.	3509 Government Ave	1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/29/49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Huntington Williams, M.D.	H. W. Meeks and Son	805 N. Calvert St.

VS 150

93E

B.C. 48-28590 ✓ 888.0

67950 Medical Ex Case

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

EN 879 Registered No. 67950

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sandra Williams
2. DATE OF DEATH: 1/25/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Hosp. 4th fl. 4 W.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-1
D. STREET ADDRESS (If rural, give location): 1028 N. Central Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	Colored		12-13-48	6 Wks				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Williams
14. MOTHER'S MAIDEN NAME: Anna V.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Johns Hopkins Hospital	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Methemoglobinemia due to ingestion of "Sweet Spirits of Nitre" — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) (Ethyl nitrite)

DUE TO (C)

CERTIFICATION APPROVED BY

Earl Rogers M.D.
CHIEF OR ASST. MEDICAL EXAMINER

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	home	1028 N. Central Avenue 10/1

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
January 25, 1949 8 a.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Overdose of "Sweet spirits of Nitre"

22. *I hereby certify that I attended the deceased from* 1/25/49 *to* 1/25/49, *that I last saw the deceased alive on* 1-25-49, *and that death occurred at* 8:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dan C. Mermann M. D.	Johns Hopkins Hospital	1-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 27/49	Mt Calvary Cem	A A County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Hunter for Williams, M.D.	Mrs. Robt. G. Edelen & Sons	1129 N. Caroline St

VS 150 Released to Hospital

179X

G70951 ✓443 450 G70951

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frank Joseph Faimann
2. DATE OF DEATH: Jan 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp.
C. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-2
D. STREET ADDRESS (If rural, give location): 712 N. Madeira St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
M	White	Married	3-25-1866	82	10			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Czech.	U. S.

13. FATHER'S NAME: Frank Faimann
14. MOTHER'S MAIDEN NAME: Mary Bohonda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Mrs. Faimann	712 N. Madeira

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 hrs.
DUE TO
(B) Hypertensive Cardio Vascular Disease
DUE TO
(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Jan 26, 1949 to Jan 26, 1949 that I last saw the deceased alive on Jan 26, 1949 and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Karl E. Person Jr. M.D.	St. Joseph's Hosp.	Jan 26, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-29-49	Holy Redeemer	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Huntington Williams, MD	Thomas Brockson	900 N. Greene

VS 150

93D

G709:52 ✓ 443 G709:52

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3223 Fait Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 S. Belinton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CAROLYN M. BACKUS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife William L. Backus
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) August 29, 1890

8. AGE: Years	Months	Days	If less than one day
58	4	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation House Work
11. Industry or business At Home.

FATHER
12. Name Levern L. Hubbard
13. Birthplace Cambridge, Md.

MOTHER
14. Maiden Name Mary E. Lewis
15 Birthplace Cambridge, Md.

16 (a) Informant Ella T. Backus
(b) Address 3223 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-49 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Eastern Ave.

18 (a) Funeral director Charles L. Zeiler
(b) Address 901 S. Conkling St.

19 JAN 27 1949 (Date rec'd by registrar) Remington-Northern Mills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1949 at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20 1949 to Jan. 24 1949 and that I last saw h[illegible] alive on Jan 23 1949

Immediate cause of death	Duration
suprapubic cystostomy	1 day
Due to carcinoma.	?
Due to —	
Other Conditions hypertension, chr. interstitial nephritis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. C. Schlicht
Address 447 N. Kenwood Ave. Date signed 1/26/49

VS 150

131a

G709:53 ✓ 420.1 G709:53

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): FRANK XAVIER LENK

2. DATE OF DEATH: Jan. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 418 N. Highland Ave. 26-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	Nov. 4, 1887	61	2	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Germany	USA

13. FATHER'S NAME: Conrad Lenk

14. MOTHER'S MAIDEN NAME: Barbara Lenpek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	WW 2- CG	?	Records- US Marine Hospital	Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary sclerosis with myocardial infarction	Unknown
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 25, 1949, *to* Jan. 25, 1949, *that I last saw the deceased alive on* Jan. 25, 49 *and that death occurred at* 7:30A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Sr. Surgeon, Clinical Director, M. D.	US Marine Hospital, Balto. Md.	1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 28-49	Balto. Meth. Cem.	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Remington for Williams M.D.	John G. Connelly	418 Eastern Ave. Balto. 24, Md.

VS 150

94a

G709:54 BALTIMORE CITY HEALTH DEPARTMENT 475 G709:54

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C 48-05394

1. NAME OF DECEASED (Type or Print) Donald Smith

2. DATE OF DEATH 1-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore 9 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE md.
B. ~~COUNTY~~
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 408 Pearl Street 17-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	negro	Single	april 1948	9 mos		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant

10B. KIND OF BUSINESS OR INDUSTRY infant

11. BIRTHPLACE (State or foreign country) Balto, maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Jerome smith

14. MOTHER'S MAIDEN NAME annie Bannister

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO —

17. INFORMANT annie B Smith ADDRESS 408 Pearl St Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) anoxia Hanoxemia	impossible to tell.
ANTECEDENT CAUSES	DUE TO (B) bronchopneumonia, bilateral	3 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) upper respiratory infection	1 wk
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(a) anemia: Hemoglobin 2 grams = 14% (b) pt expired while blood was being drawn from external jugular vein for laboratory tests.	

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 1-25, 1949 *to* 1-25, 1949 *that I last saw the deceased alive on* —, 19— *and that death occurred at* 10:30A m., *from the causes and on the date stated above.*

23A. SIGNATURE J. R. Hankins M. D.

23B. ADDRESS University Hospital

23C. DATE SIGNED 1-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE I-27-49

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn

24D. LOCATION (City, town, or county) (State) Baltimore 30, Md.,

DATE RECEIVED BY LOCAL REGISTRAR JAN 27 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR W. A. JACKSON ADDRESS 916 PENNA, AVE

VS 150

107

G70955 ✓ G70955

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331 Registered No.

1. NAME OF DECEASED (Type or Print): Bernardina Di Fasio

2. DATE OF DEATH: Jan. 25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3504 E. Pratt St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 35 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 3717 E. Pratt St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	May 1st 1893	55	8 / 24	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Campagna Italy	

13. FATHER'S NAME: Luigi Luordo

14. MOTHER'S MAIDEN NAME: Paolina Tretta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	no	Antonia Di Fasio	3717 E. Pratt St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 72 hours
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertension
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 6, 1949 *to* Jan. 25, 1949, *that I last saw the deceased alive on* Jan. 25, 1949, *and that death occurred at* 10:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John LoCantini M. D.	234 S. Conkling Street	1-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 26 1949	St. Stanislaus	Mt. Carmel Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Huntington Williams, M.D.	Frank Della Cool	322 S. High St.

VS 150

83a

GM 126364 G709:56 ✓ G709:56

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 443

Registered No.

1. NAME OF DECEASED (Type or Print): Maggie W. Deshields

2. DATE OF DEATH: 1-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern ave
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 303 N. Stricker St 19-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	"arried	4-14-18?8	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook	Domestic	Md	U.S.A.

13. FATHER'S NAME: William Wilson

14. MOTHER'S MAIDEN NAME: Sarah "atson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Records Balto. City Hosp ADDRESS: Eastern 4940

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) H.C.V.D. Severe failure — DUE TO
(B) Hypertension — DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Old CVA. left.

INTERVAL BETWEEN ONSET AND DEATH
(A) 1 yr.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-25, 1949 *to* 1-25, 1949, *that I last saw the deceased alive on* 1-25, 1949, *and that death occurred at* 8:30P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Merrill F Nelson M. D.	CBCH	1-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/29/49	Mt Calvary	A. G. County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Huntington Williams M.D.	Chas Harper	51 E Lanvale St

To Be Approved by the Chief Medical Examiner 927

G709:57 BALTIMORE CITY HEALTH DEPARTMENT G709:57

CERTIFICATE OF DEATH 443

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Bryant

2. DATE OF DEATH: 1/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 621 W. Lafayette Ave.
C. Length of stay in Baltimore: 15 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 621 W. Lafayette Ave. 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	Married	3-10-1895	53	10	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Dover, N. C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Keddin Bryant
14. MOTHER'S MAIDEN NAME: Hattie Rhodes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W. W. #1
16. SOCIAL SECURITY NO.:
17. INFORMANT: Pearl Bryant(wife) ADDRESS: 621 W. Lafayette Ave.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-31-49	Baltimore National	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles G. Cooper ADDRESS: 512 N. Carrollton Ave.

45 151

939

G709:58

BALTIMORE CITY HEALTH DEPARTMENT 762.5 G709:58

BIRTH NO. B.C. 49-01616 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): Marga Louise Hollau

2. DATE OF DEATH: Jan 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp.

c. Length of stay in Baltimore: 15 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 28-4
D. STREET ADDRESS (If rural, give location): 503 Glen Allen Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	w		Jan 25, 1949				9	43

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elmer Wilson Hollau

14. MOTHER'S MAIDEN NAME: Carolyn Gordon Blass

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Elmer Hollau ADDRESS: 503 Glen Allen Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity
DUE TO Atelectasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-25 19 49 *to* 1-26 19 49, *that I last saw the deceased alive on* 1-26 19 49, *and that death occurred at* 4 15 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.: Henry Cohen

23B. ADDRESS: Balto General Hosp.

23C. DATE SIGNED: 1-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): 24B. DATE: Jan. 27 1949

24C. NAME OF CEMETERY OR CREMATORY: Western

24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 27 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Harry A Stifler ADDRESS: 4101 Edmondson Av

VS 150

159

G709:59 ✓ 592 44 G709:59

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Holston, Mrs Alice Gertrude

2. DATE OF DEATH 1-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore 30 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-15
D. STREET ADDRESS (If rural, give location) 5722 Cross Country Bouleyard

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Dec. 30, 1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10B. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Baltimore Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nicholas Uhler

14. MOTHER'S MAIDEN NAME: Annie Spurrier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ---

17. INFORMANT: W. Frank Holston ADDRESS: 5722 Cross Country Blvd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive C.V. Disease ½ Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Renal Disease — probably Chr. glomerulo nephritis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-18, 1949 *to* 1-25, 1949 *that I last saw the deceased alive on* 1-25, 1949, *and that death occurred at* 3:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Arlie R Mannenger M. D.

23B. ADDRESS University Hospital

23C. DATE SIGNED 1-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 28, 1949	Druid Ridge	Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 27 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

VS 150

131B

G70960 ✓161 G70960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VINCENTAS BUBLISIO OR WILLIAM BOBOL

2. DATE OF DEATH 1-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Univ Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 210 W. Camden St. 22-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W		Not know	60?				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Porter		?	U.S.

13. FATHER'S NAME ? Bublisio

14. MOTHER'S MAIDEN NAME Not know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
UNKNOWN —	212-20-6633	John A Grebliunckas Jr	423 S Loca St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Lung
DUE TO
(B) c cirrhosis of cirrhosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(INTERVAL BETWEEN ONSET AND DEATH) ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12-8-48	Ca. of lung c local metastasis	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-4-49, 19__, *to* 1-25-49, 19__, *that I last saw the deceased alive on* 1-25, 1949, *and that death occurred at* 3:15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Kyle Y. Swisher Jr. M. D.	Univ. Hosp. - Balto, Md	1-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 28-49	Trinity Cem.	5500 O'Donnell Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Huntington Williams M.D.	John A Grebliunckas Jr	423 S Loca St

VS 150

47a

Dr. Sawyer

G70961

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

151

Registered No. G70961

1. NAME OF DECEASED (Type or Print): Emma C. Hens

2. DATE OF DEATH: Jan. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2905 White Avenue
c. Length of stay in Baltimore: Yrs. 27 Mos. 6 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2905 White Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	widowed	Apr. 10, 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Maryland	

13. FATHER'S NAME: Theodore Sacks

14. MOTHER'S MAIDEN NAME: ? Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Mr. Arnold Hens, 2905 White Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	carcinoma of stomach	6 mos.
DUE TO (B)	—	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	atropuic arthritis	15 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 20, 1945 *to* Jan. 26, 1949, *that I last saw the deceased alive on* Jan. 25, 1949, *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. Sawyer M. D.	4808 Harford Rd.	1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-29-49	Parkwood Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 27 1949	[illegible]	Leonard J. Ruck, 5305 Harford Road.

VS 150

46B

G70962
Dr. Haase

443 G70962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Georgianna Rigor

2. DATE OF DEATH: Jan. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3206 Rosekemp Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 3206 Rosekemp Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
female	white	widowed	June 11, 1863	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Boone

14. MOTHER'S MAIDEN NAME: Aeriel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mr. Harold Rigor, ADDRESS: 3206 Rosekemp Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Congestive heart failure	10 days
DUE TO (B)	Hypertension C.V.D.	?
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Arteriosclerosis - marked	

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1948, *to* Jan 25, 1949, *that I last saw the deceased alive on* Jan 25, 1949, *and that death occurred at* 9 00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Hanson Haase M.D. M.D.

23B. ADDRESS: 4218 Harford Rd.

23C. DATE SIGNED: Jan 26 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1-28-49	Greenmount Cem.	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 27 1949

REGISTRAR'S SIGNATURE: Hunting for Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road

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G70963 ✓153 G70963

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Adam Joseph Petersam
2. DATE OF DEATH: Jan 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1605 Darley Ave. 1-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Married	11/13/1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Accountant		Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Heinrich Petersam	Catherine ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Margaret Petersam	1605 Darley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Sigmoid — (Interval between onset and death)
DUE TO
(B) with Metastasis to Liver
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: ① Rheumatic heart ② Cyst U. kidney → Congestion

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 22, 1949 *to* Jan 26, 1949 *that I last saw the deceased alive on* Jan 26, 1949 *and that death occurred at* 6:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Karl Peterson Jr. M.D.	St. Josephs Hosp.	Jan 26 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-31-49	Holy Redeemer	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Huntington Williams M.D.	L. J. Luck	5305 Harford

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO B.C. 49-01389 Registered No.

1. NAME OF DECEASED (Type or Print) Chas. Grant Miller jr

2. DATE OF DEATH 1-27-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore 100

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1722 Pratt, St

c. Length of stay in Baltimore 36 hrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 1722 E Pratt, St

5. SEX Boy | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Infant | 8. DATE OF BIRTH 1-25-49 | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. 36 hrs

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | 10B. KIND OF BUSINESS OR INDUSTRY Infant | 11. BIRTHPLACE (State or foreign country) Baltimore City | 12. CITIZEN OF WHAT COUNTRY? U of S.

13. FATHER'S NAME Chas. Grant, Miller Jr | 14. MOTHER'S MAIDEN NAME Mary Louise Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. — | 17. INFORMANT Infants mother ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Premature (30 wks) — INTERVAL BETWEEN ONSET AND DEATH: 96 hrs

DUE TO

(B) Hyaline membrane

DUE TO

(C) Premature

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — | 19B. MAJOR FINDINGS OF OPERATION — | 20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 1-25-49, 19__, *to* 1-27, 1949, *that I last saw the deceased alive on* 1-27/49 19__. *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Robt Summerour M. D. | 23B. ADDRESS 1838 Garrison Blvd | 23C. DATE SIGNED 1-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE JAN 28 1949 | 24C. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY | 24D. LOCATION (City, town, or county) (State) NORTH AVE & GAY ST MD

DATE RECEIVED BY LOCAL REGISTRAR JAN 27 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Diffel Bros. ADDRESS 1800 E Lombard St

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Ann Moran
2. DATE OF DEATH: Jan. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Bon Secours Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Woodlawn
D. STREET ADDRESS (If rural, give location): 2400 Poplar Grove

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	W	Single	May 7, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Ireland	

13. FATHER'S NAME: Timothy Moran
14. MOTHER'S MAIDEN NAME: Anna Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Agnes C. Grannes - 2400 Poplar Grove

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Accident (embolus)	
DUE TO (B)	Adeno-Carcinoma Stomach	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH: BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Arteriosclerotic heart disease	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/19/49	metastatic carcinoma stomach	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 10, 1949, *to* Jan 25, 1949, *that I last saw the deceased alive on* Jan. 25, 1949, *and that death occurred at* 11:55 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. S. Mohler M.D.	Bon Secours Hosp.	1/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/28/49	Cathedral	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JAN 27 1949	[illegible] Williams M.D.	George A. Fosley Fulton Ave & Fayette

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): TARR ANNIE E.

2. DATE OF DEATH: January 27 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto Co.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in Hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. — Mos. 3 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Halethorpe
D. STREET ADDRESS (If rural, give location) 1704 Summit Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year Months Days	If under 24 hours Hours Min.
Female	White	widowed	11-19-1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Baltimore - Md.	USA

13. FATHER'S NAME: John Simmons

14. MOTHER'S MAIDEN NAME: Annie Fuld

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		none	Mrs. Edith E. Riggan	1704 Summit Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure ~~Acute Cholecystitis & Cholecystotomy~~

DUE TO

(B) Hypertension & Arteriosclerosis C-V Disease

DUE TO

(C) Arteriosclerosis (Generalized)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Post-operative Cholecystotomy for Acute Cholecystitis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-22-49	Acute Cholecystitis	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-21 , 1949 *to* 1-24 , 1949 *that I last saw the deceased alive on* 1-24 ; 1949 *and that death occurred at* 9:40A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Hightower M. D.	University Hospital	1-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 27-49	Loudon Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Huntington Williams M.D.	H. R. Hubbard Son	1800 Eutaw Pl

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Ethel Woodson

2. DATE OF DEATH: 1-22-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto city

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1607 Wald St

c. Length of stay in Baltimore: 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1607 Waldo St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	C	M	Dec. 29-1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Pamplin Va	U.S.A.

13. FATHER'S NAME: Martin Womack

14. MOTHER'S MAIDEN NAME: Edmonia Harvey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Genava Abbott	2114 Pulaski St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Mitral insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 day.
DUE TO
(B) hypochromic anemia — 6 months
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hepatic Cirrhosis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-18 , 1948, *to* 1-22 , 1949, *that I last saw the deceased alive on* 1-22 , 1949, *and that death occurred at* 1:P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. C. Brownell M. D.	1Y1 Aisquith	1-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 29-49	Daughters of Zion	Pamplin Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Lexington Williams, M.D.	Elwood S. Wilson	Beaufty Va

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No. 1949

1. NAME OF DECEASED (Type or Print) MOSES SPIELDOCK.

2. DATE OF DEATH JANUARY 26th-

3. PLACE OF DEATH: A. Baltimore City, Maryland 3418 Park Heights

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE SAME B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore- Md

D. STREET ADDRESS (If rural, give location) 1517

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	WIDOWER	APRIL 3rd-1864	84	9	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED BARBER	BARBER	SAVANNAH .GA.	U-S-A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
LEOPOLD SPIELDOCK.	MINNA STERN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
X	X	X	ALVIN SPIELDOCK	3418 PARK HEIGHTS A

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIO - Respiratory Failure

DUE TO

(B) Arteriosclerotic C V D.

DUE TO

(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

SENILITY

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Apr 24 *, 19*47 *to* Jan 27 *, 19*49 *that I last saw the deceased alive on* Jan 27 *, 19*49 *, and that death occurred at* 12-M *. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Willard Applefeldt M. D.	2511 Reisterstown Rd	1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JAN 28th-49	HEBREW FRIENDSHIP	BALTO & WONKLIN STS

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	Huntington Williams, M.D.	J. AHRENS & CO	2432 REISTERSTOWN RD

VS 150

937

G709-69

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G709-69

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES ADAMS — 204.1

2. DATE OF DEATH: Jan. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: 15 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Fla.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lakeland
D. STREET ADDRESS (If rural, give location): 616 N. Texas Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Single	10/25/16	32	3	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Oiler	Seafarer	Ashford, Ala.	USA

13. FATHER'S NAME: Joseph Adams

14. MOTHER'S MAIDEN NAME: Dora Harper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		?	Records- US Marine Hospital	Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute leukemia probably of the monocytic type — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(over)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Jan. 12, 1949, *to* Jan. 27, 1949 *that I last saw the deceased alive on* Jan. 27 1949 *and that death occurred at* 5:03A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Sr. Surgeon, Clinical Director, M. D.	US Marine Hospital, Balto, Md.	1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1-27-49	Ward & Wilson Funeral Home	Dothan Alabama

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 27 1949	[illegible]	Earl D Wolverton	403 E 25th St 74a

WORLD WAR II VETERAN

G709.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G709.0

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Luther H. Willoughby

2. DATE OF DEATH: 1/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sykesville
D. STREET ADDRESS (If rural, give location):

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 6, 1898
9. AGE (In years last birthday): 50 51
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brakeman
10B. KIND OF BUSINESS OR INDUSTRY: B&O Railroad
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard Willoughby
14. MOTHER'S MAIDEN NAME: Catherine Cash

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-01-0268
17. INFORMANT: Zora Willoughby ADDRESS: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) 2nd-3d° Burns of

(B) DUE TO Body Surface

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): East of the Crossing at Sykesville
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 22 49 2:40 p.m.
21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Steam from derailed locomotive Train Wreck

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 29, 1949
24C. NAME OF CEMETERY OR CREMATORY: Springfield
24D. LOCATION (City, town, or county) (State): Howard Co, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry Weer ADDRESS: Sykesville, Md.

VS 15 JAN 28 1949

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G709.1 ✓ 421.4 G709.1

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Fannie Elizabeth Schmidt

2. DATE OF DEATH 1-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto, Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 503 Radnor Ave

c. Length of stay in Baltimore Life — Yrs. Life, Mos. , Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 503 Radnor Ave 2 7 10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Widowed	2-4-1876	72	11 / 17	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Balto Md	

13. FATHER'S NAME Francis Kelly

14. MOTHER'S MAIDEN NAME Mary K. ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Joseph G Schmidt	503 Radnor Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute Dilatation Heart	5 min.
DUE TO (B)	Chr. Endocarditis	10 yrs.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Chr. Valvular Disease	10 yrs
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 10, 1949, to Jan. 26, 1949, *that I last saw the deceased alive on* Jan. 25, 1949, *and that death occurred at* 1 05 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Carl H Benson, M.D. M. D.	5111 York Rd	Jan. 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/28/49	Balto	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS/50 JAN 28 1949

92D

G709?2 581.0 ✓ G709?2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Dr. Frank Saunders Hundley

2. DATE OF DEATH: January 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2305 St Paul St

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2305 Saint Paul St. 12 4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Feb 3, 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Physician	self	Baltimore, Md.	

13. FATHER'S NAME: Booker T. Hundley

14. MOTHER'S MAIDEN NAME: Alice Saunders

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
yes	World War 1 & 2		Margaret A. Hundley	2305 Saint Paul St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Hemorrhage — Interval between onset and death: Instant

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Oesophageal Varices — ?

DUE TO

(C) Cirrhosis of the Liver — 3 years.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19??, *to* Jan. 25, 1949, *that I last saw the deceased alive on* 1/25, 1949, *and that death occurred at* 7:35 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	720 E. Preston St.	1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 28, 1949	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams, M.D.	William Cook Inc.	1217 Saint Paul St.

JAN 28 1949

124B

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G709?3

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G709?3

Registered No.

1. NAME OF DECEASED (Type or Print): Pearl Hood

2. DATE OF DEATH: 1/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital - Baltimore
C. Length of stay in Baltimore: 2 DAYS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Severn
D. STREET ADDRESS (If rural, give location):

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: April 18, 1889
9. AGE (In years last birthday): 59
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: William Boyer
14. MOTHER'S MAIDEN NAME: Janey Gardner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: John N. Jenkins
ADDRESS: Severn Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio Sclerotic Cardio-vascular Disease with severe decompensation

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Marked Kyphosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 23, 1948, *to* Jan 26, 1949, *that I last saw the deceased alive on* Jan 26, 1949, *and that death occurred at* 4.45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Frank E Brumback M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-29-49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): Brooklyn, R. F. D.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Thomas W. Singleton - Glen Burnie
ADDRESS:

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93D

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO B.C. 49-01490

1. NAME OF DECEASED (Type or Print): Baby Girl MaThews - A

2. DATE OF DEATH: 1-16-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Womans Hospital

C. Length of stay in Baltimore: less than ~~1 Mos.~~ 1 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rockdale (Rural)
D. STREET ADDRESS (If rural, give location): Mayfield Ave & Parkes Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Wh	S	1-16-49			1 / 29

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-	-	Maryland	U.S.

13. FATHER'S NAME: Thomas (none) Matthews

14. MOTHER'S MAIDEN NAME: Minnie May Parkes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no no	-	Mother	above

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Developmental Immaturity — INTERVAL BETWEEN ONSET AND DEATH: 1 hr 29 min

DUE TO

(B) Premature labor

DUE TO

(C) 5 months gestation

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
-	-	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
-	-	-

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
- m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	-

22. *I hereby certify that I attended the deceased from* 1-16, 19 49 *to* 1-16, 19 49 *that I last saw the deceased alive on* 1-16, 19 49, *and that death occurred at* 12 M *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Warren C. Kelly M. D.	Woman's Hospital	1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		University Medical School	JAN 19 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C. 49-01491

1. NAME OF DECEASED (Type or Print) Baby Boy MaTThews - B

2. DATE OF DEATH 1-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Woman's Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rockdale (Rural)
D. STREET ADDRESS (If rural, give location) Mayfield Ave + Parker Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
Male	White	Single	1-16-49			53

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Maryland.	U.S.

13. FATHER'S NAME Thomas (None) Matthews

14. MOTHER'S MAIDEN NAME Minnie May Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no	—	mother	above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Developmental Immaturity — INTERVAL BETWEEN ONSET AND DEATH: 53 min

DUE TO

(B) Premature Labor

DUE TO

(C) 5 mo. gestation

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 1-16- , 1949 *to* 1-16 , 1949 *that I last saw the deceased alive on* 1-16 , 1949 *and that death occurred at* 11:3 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Vernon C Kelly M. D.	Woman's Hospital	1-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		University Medical School	JAN 19 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL	ADDRESS
JAN 28 1949	Tentatively for Williams, M.D.	Commissioner of Health	

VS 150

159

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): IGNATZ STEPANUK

2. DATE OF DEATH: January 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 119 S. Spring Street 3-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white		Unknown	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown		Unknown	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) A.S.C.V.D. (arteriosclerotic cardiovascular disease)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 1/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	JAN 21 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 28 1949	Huntington Williams, M.D.	Commissioner of Health

VS 151

Please type or print plainly. Physician: please write the cause of death clearly and legibly.

6:09.7 ✓ 475 6:09.7

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B-C-49-02347

1. NAME OF DECEASED (Type or Print) NATHAN BOLLER

2. DATE OF DEATH Jan. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 410 North Pearl Street 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	S	Jan. 8, 1949			3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
———	———	Unknown	U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	———	———	Unknown	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Upper respiratory infection

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George L. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 1/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	JAN 21 1949

DATE RECEIVED BY LOCAL REGISTRAR JAN 28 1949

REGISTRAR'S SIGNATURE for Williams, M.D.

25. FUNERAL DIRECTOR Commissioner of Health ADDRESS

VS 151

1042

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALEXANDER ABRAMOVITZ
2. DATE OF DEATH: 1-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 210 No Collington Ave
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6 07
D. STREET ADDRESS (If rural, give location): 210 No Collington Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married		54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bartender		Baltimore Md	

13. FATHER'S NAME: Nathan
14. MOTHER'S MAIDEN NAME: Fannie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes World War 2		Retta Abramovitz	210 No Collington Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Aug 1948	Carcinoma of Stomach.	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 27, 1948, to Jan 27, 1949, *that I last saw the deceased alive on* 1-27, 1949, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. W. Jacobson MD M. D.	2310 Eutaw Place	1-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-28-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Thurlington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

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J1 - 126356

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Emory

2. DATE OF DEATH: Jan. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 2 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Anne Arundel
Crownsville State Hospital, Md
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	C	?	?	70 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Jan. 27, 1949	Amputation for Gangrene of Rt. Foot.	YES XXX NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 25, 1949 *to* Jan. 27, 1949, *that I last saw the deceased alive on* Jan. 27, 1949, *and that death occurred at* 2.10 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. S. Rogers M. D.		

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremd	1-26-49	St Stephens	Elkridge Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams, M.D.	J. C. Higginbotham	Ellicott City Md

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G70980

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nathaniel Palm

2. DATE OF DEATH: 1-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 11 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1255 W Fayette ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	S	Nov. 12-1903(?)	35(?)		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): S.C.
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: John Palm
14. MOTHER'S MAIDEN NAME: Josephine Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Records Balto. City Hospitals ADDRESS: 4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) For Advanced Pulmonary Tuberculosis	1 year
	DUE TO	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Parkinsonism Malnutrition	6 mos

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 1-4, 1949, *to* 1-15, 1949 *that I last saw the deceased alive on* 1-15, 1949, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Margaret A. Morgan M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 1-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School
24D. LOCATION (City, town, or county) (State): JAN 24 1949

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

13B

G70981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

762.5

Registered No. G70981

BIRTH NO. B.C.49-01973

1. NAME OF DECEASED (Type or Print): Baby Boy Mesinger

2. DATE OF DEATH: Jan 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 2911 Keswick Rd. 13-05

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: Male
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Jan. 20. 1949
9. AGE (In years last birthday): If Under 1 Year: Months Days; If Under 24 Hours: Hours 1, Min. 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Glenn. Clarence Mesinger
14. MOTHER'S MAIDEN NAME: Margaret Cecilia Ganon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Margaret Mesinger ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia - Atelectasis
DUE TO Prematurity (11 oz 6 mo.)
(B) Premature separation Placenta
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 20, 1949 to Jan 20, 1949 *that I last saw the deceased alive on* Jan 20, 1949, *and that death occurred at* 5:00 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry Cohen M. D.
23B. ADDRESS: Baltimore General Hosp.
23C. DATE SIGNED: 1/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School
24D. LOCATION (City, town, or county) (State): JAN 24 1949

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Commissioner of Health ADDRESS:

VS 150

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754.4 G70982

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-01782 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Boy Paige

2. DATE OF DEATH: January 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore, Inc.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 16-7
D. STREET ADDRESS (If rural, give location): 3008 Littletop Rd. Littleton

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Jan. 16, 1949
9. AGE (In years last birthday): If Under 1 Year — Months: Days: 6 — If Under 24 Hours — Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Paige
14. MOTHER'S MAIDEN NAME: Jane Wheeley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Jane Paige ADDRESS: 3008 Littletop Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Subdural hemorrhage	6 days
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	congenital heart disease	6 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 16 January, 1949, *to* 22 January, 1949, *that I last saw the deceased alive on* 22 January 1949, *and that death occurred at* 4:10 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: William V. Gross, Jr. M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 24 January 1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School
24D. LOCATION (City, town, or county) (State): JAN 24 1949

DATE RECEIVED BY LOCAL REGISTRAR: JAN 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health ADDRESS:

VS 150

160a

G70983 ✓ 712.5 G70983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-01445 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Antiedel
2. DATE OF DEATH: 1/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital
C. Length of stay in Baltimore: 4hrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
D. STREET ADDRESS (If rural, give location): 1929 E. Belvedere Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	W	S	1/18/49			4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Allen Antiedel
14. MOTHER'S MAIDEN NAME: Mary June Clogg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Hospital Records ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fetal atelectasis

DUE TO

(B) Prematurity

DUE TO [redacted] Ilb 144

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0	0	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
0	0	0

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
0 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	0

22. *I hereby certify that I attended the deceased from* 1/18, 1949 *to* 1/18, 1949 *that I last saw the deceased alive on* 1/18, 1949, *and that death occurred at* 3:45 p.m., *from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Whitehead Jr M. D.	Church Home & Hospital	1/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
0		Johns Hopkins Medical School	JAN 24 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Timothy for Williams, M.D.	Commissioner of Health	

VS 150

159

Please write the cause of death clearly and legibly. Physician: Special attention is called to importance of correct age in reporting deaths of infants.

B.C. 49-01312 ✓ 760.5

G#70984

BIRTH NO. G#70984

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G#70984

1. NAME OF DECEASED (Type or Print): Bailey Helen Hanna

2. DATE OF DEATH: January 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 200 W. 21st St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Child	1-23-49			1

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-23, 1949 *to* 1-23, 1949 *that I last saw the deceased alive on* 1-23, 1949, *and that death occurred at* 8 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Eugene O. Goldston, M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hosp Disposal
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949
REGISTRAR'S SIGNATURE: Tuttle Williams, M.D.
25. FUNERAL DIRECTOR: ADDRESS:

VS 150

Hospital Disposal

160a

Please write the cause of death clearly and legibly. Physician is especially important.

B.C. 49-00034 ✓ 7545

G70985

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G70985

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Stanton

2. DATE OF DEATH: January 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days: 20 days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-32
D. STREET ADDRESS (If rural, give location): 2807 Booker Drive (Cherry Hill)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	negro	single	January 1, 1949		20	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wilson Stanton

14 MOTHER'S MAIDEN NAME: Idella Fowlkes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Idella Stanton ADDRESS: 2807 Booker T Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure
DUE TO
(B) Coarctation of the aorta
DUE TO
(C) congenital heart disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 20 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 1-49, 19__, *to* Jan. 21, 1949, *that I last saw the deceased alive on* Jan. 21, 1949, *and that death occurred at* 5:05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Glen G. Rice M. D.
23B ADDRESS: 601 North Broadway
23C. DATE SIGNED: 1-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Ft of Dr Loads
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949
REGISTRAR'S SIGNATURE: Washington Nurseries, Md
25. FUNERAL DIRECTOR:
ADDRESS:

157E

Please write the cause of death clearly and legibly. Physician: please write age in years if under one year, in months if under one month, in days if under one day. Important.

G70986 B.C. 1951017 ✓ 776 G70986

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Wilmer Pole Webster III

2. DATE OF DEATH: 1/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Maryland General

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Parents address B. COUNTY 3026 Keen Roseland Ave #16
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27 - 16
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	—	1/18/49	—	—	9

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland General Hospital
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Wilmer Pole Webster Jr.
14. MOTHER'S MAIDEN NAME: Ida Mae Higgins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.
17. INFORMANT: Ida Webster ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO

ANTECEDENT CAUSES
(B)
DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) Respiratory failure and cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 8 hours

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 1 PM 1/18 19 49 *to* 10 PM 1/18 19 49, *that I last saw the deceased alive on* 10 PM 1/18 19 49 *and that death occurred at* 10 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Albert A. Jones Jr. M. D.
23B. ADDRESS: Maryland General Hospital
23C. DATE SIGNED: 1/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): —
24B. DATE: —
24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School
24D. LOCATION (City, town, or county) (State): JAN 25 1949

DATE RECEIVED BY REGISTRAR: JAN 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 150

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collect age is especially important. Physician: please write the cause of death clearly and legibly.

G70987 ✓ 776 G70987

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-01610 Registered No.

1. NAME OF DECEASED (Type or Print): William Thomas Puller
2. DATE OF DEATH: Jan 23, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp.
c. Length of stay in Baltimore: 23 yrs.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1707 Warwick Ave
5. SEX: Male
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Jan 23 1949
9. AGE (In years last birthday) / If Under 1 Year: Months Days / If Under 24 Hours: Hours Min.: 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Hubert Garland Puller Jr.
14. MOTHER'S MAIDEN NAME: Margaret Ann Stancill
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mother
ADDRESS: 1707 Warwick Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity (wt 11b 4 1/4 g.)

DUE TO

(B) Mother a Repeated Aborter.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-23, 1949, *to* 1-27, 1949 *that I last saw the deceased alive on* 1-27-49, 19____ *and that death occurred at* 9:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Harry Cohen M. D.
23B. ADDRESS: Johns Hopkins Hosp.
23C. DATE SIGNED: 1-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School
24D. LOCATION (City, town, or county) (State): JAN 25 1949

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 150

159

G70988 BC-49-01023 ✓ 760.0 G70988

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Raymond Figgs Jr.

2. DATE OF DEATH: 1/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: Yrs. — Mos. — Days —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 9 E. Oxford Newborn
B. COUNTY H #30
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 22-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	—	1/22/49			3 / 13

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Maryland	U.S.

13. FATHER'S NAME: Charles Raymond Figg

14. MOTHER'S MAIDEN NAME: Marion Bowen Legg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Marion Figgs — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs
DUE TO
(B) Probable Birth Injury
DUE TO
(C) Respiratory Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 1/21/49, 19—, *to* 1/22, 1949, *that I last saw the deceased alive on* 1/22, 1949, *and that death occurred at* 12:20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert R. Jones Jr. M.D.	Maryland General Hospital	1/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
—	—	Johns Hopkins Medical School	JAN 25 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Emerson Williams, M.D.	Commissioner of Health	

VS 150

160a

G70983

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

578 (2)

Registered No. G70983

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Andrew G. Engelhart

2. DATE OF DEATH: January 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1136 Harford Avenue 10-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Sep.	4/24/12	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed	Machinist	Baltimore, Maryland	

13. FATHER'S NAME: Joseph Engelhart

14. MOTHER'S MAIDEN NAME: Barbara Behring

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Generalized peritonitis	
DUE TO	Ruptured sigmoid diverticulum	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	① Pneumonia ② Fatty liver	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/23/ , 1949 *to* 1/26/ , 1949 *that I last saw the deceased alive on* 1/26/ , 1949 *and that death occurred at* 5:10 AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Joseph Kreyer M. D.	1400 N. Caroline Street	1/26/49

24A. BURIAL / CREMATION / REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 29, 1949	Holy Redeemer	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 28 1949	Huntington Williams M.D.	Rita Wiedefeld 900 East Biddle St

VS 150

124 B

Object age is especially important. Physician: please write the cause of death clearly and fully.

G70990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 331

Registered No. G70990

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD SCHOOL

2. DATE OF DEATH: January 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): One Spot
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	U		65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U

10B. KIND OF BUSINESS OR INDUSTRY: K

11. BIRTHPLACE (State or foreign country): U

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: N O

14. MOTHER'S MAIDEN NAME: N K

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): W N

16. SOCIAL SECURITY NO

17. INFORMANT: U ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) 6

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George L. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 1-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School

24D. LOCATION (City, town, or county) (State): JAN 26 1949

DATE RECEIVED BY LOCAL REGISTRAR: JAN 26 1949

25. FUNERAL DIRECTOR: Commissioner of Health ADDRESS

Commissioner of Health

VS 151

834

✓ 153

G70991

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G70991

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GOLDSMITH HARDING

2. DATE OF DEATH Jan. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1613 Penna, Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1613 Pennsylvania Ave.

C. Length of stay in Baltimore 44 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1613 Pennsylvania Ave. 14-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Widow	May 9, 1889	59	8	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Springfield, Ark.	U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-24-8958

17. INFORMANT Mrs. Lucy Upton ADDRESS 1613 Penna. Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heart failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Generalized abdominal carcinomatosis

DUE TO Carcinoma of ascending colon

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 1948	Ca of colon with metastasis	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/21, 1949 *to* 1/22, 1949, *that I last saw the deceased alive on* 1/21, 1949 *and that death occurred at* 7 A. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. W. Holler M. D.	Provident Hosp	1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 28th 1949	Arbutus Mem. Pk.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	[illegible]	Wm. Geo. H. Holland	1637 Druid Hill Ave

VS 150

46E

Correct age is especially important. Physician please write the cause of death clearly and legibly.

G70992 ✓022 G70992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BERNARD BOTKIN

2. DATE OF DEATH: Jan. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 117 N. Front St. 5-1

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): ✓
8. DATE OF BIRTH: 9/28/95
9. AGE (In years last birthday): 53 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME: Laurence Botkin
14. MOTHER'S MAIDEN NAME: Margaret Greer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cardiac failure	7 days
DUE TO (B)	Syphilitic aortitis & aneurysm	
DUE TO (C)	and aortic insufficiency	1 yr
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/17, 1949 *to* 1/20, 1949 *that I last saw the deceased alive on* 1/20, 1949 *and that death occurred at* 10:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: William W. Wasserman M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School
24D. LOCATION (City, town, or county) (State): JAN 26 1949

DATE RECEIVED BY LOCAL REGISTRAR: JAN 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR — ADDRESS: Commissioner of Health

VS 150

301

collect age is especially important. Physician please write the cause of death clearly and legibly.

G70993

754.3

G70993

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C. 49-01907

1. NAME OF DECEASED (Type or Print): Sandra Wood

2. DATE OF DEATH: 1/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
913. W. 33rd St - Balto Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)
12-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W		1/25/49		—	—	5	30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Walter Frank Wood	Bernice Grace Weston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Bernice Wood	913 W 33rd St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intra auricular Septal Defect
DUE TO Bilateral Polycystic Kidneys
Sub dural Hematoma.
(B) Encephalocoele
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/25/49, 19__, *to* 1/26/49, 19__, *that I last saw the deceased alive on* 1/26/49, 19__, *and that death occurred at* 2:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert A. Janes Jr. M. D.	Maryland General Hospital	1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	JAN 27 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	[illegible]	Commissioner of Health	

VS 150

157E

G70994 ✓ 772.0 491 G70994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.-48-27618 Registered No.

1. NAME OF DECEASED (Type or Print): Portia McNair

2. DATE OF DEATH: January 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 5 weeks (Yrs. + Mos. Days)

D. STREET ADDRESS (If rural, give location): 525 Dolphin St. 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro		12-20-48		1	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John McNair

14. MOTHER'S MAIDEN NAME: Hattie Randell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: John McNair - Father ADDRESS 525 Dolphin

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho pneumonia Bilat. (Age) — INTERVAL BETWEEN ONSET AND DEATH: 12 hours.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Marasmus

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 1-26, 1949 to 1-26, 1949 that I last saw the deceased alive on 1-26, 1949, and that death occurred at 5:45 m. from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. O'Brien M. D.	President Hospital	1-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 28, 1949	Arbutus Mem. Park	Balto. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Wm. George H. Holland ADDRESS: 1601 Edmondson Ave

VS 150

107

G70995 ✓ 420.1 G70995

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Boyd A. White

2. DATE OF DEATH 1-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore 50 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1909 - Division St. 14-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Negro	Married	6-2-77	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed	None	Matthews Co. Va.	U. S. A.

13. FATHER'S NAME Raphael Frank White

14. MOTHER'S MAIDEN NAME Sarah Spriggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Mrs. Ruth White	1909 Division St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Myocardial Infarction

DUE TO

(C) Pulmonary Edema Congestion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 1-23- 1949, to 1-26 1949, that I last saw the deceased alive on 1-26, 1949, and that death occurred at 2:45 m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. C. Bradley M. D.	Provident Hospital	1-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 28 1949	Family Lot	Matthews Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams M.D.	Jno. George W. Holland	1681 Druid Hill

VS 150

94a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

C70996

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581.1

C70996

Registered No.

1. NAME OF DECEASED (Type or Print) ROBERT NEUMAN

2. DATE OF DEATH 1/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 923 S. Ellwood Ave. #24 1-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	M	July 8, 1903	45	6 19	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gustav. Neuman

14 MOTHER'S MAIDEN NAME Emma Flitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT ADDRESS Grace M. Neuman 923 S. Ellwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gastro-intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bleeding esophageal + rectal varices — 6 months

DUE TO

(C) Portal Cirrhosis — ? years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia, right lower lung — 1 week

Chronic Alcoholism — ? years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/27, 1949 *to* 1/27, 1949 *that I last saw the deceased alive on* 1/27, 1949, *and that death occurred at* 7 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE Alfred H. Dann M. D.

23B. ADDRESS Maryland General Hosp.

23C. DATE SIGNED 1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1/31/49

24C. NAME OF CEMETERY OR CREMATORY Schwartz's

24D. LOCATION (City, town, or county) (State) O'Donnell St.

DATE RECEIVED BY LOCAL REGISTRAR JAN 28 1949

REGISTRAR'S SIGNATURE Remington Williams M.D.

25 FUNERAL DIRECTOR Clarence P. Hoffman ADDRESS 37 Broadway

124a

Please write in ink, with UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician please write the cause of death clearly and legibly.

G70997 ✓ 762,5 G70997

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-03911 Registered No.

1. NAME OF DECEASED (Type or Print) David Michael GARDNER
2. DATE OF DEATH 27 Jan 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital Calvert & Saratoga Balto 2 Md
C. Length of stay in Baltimore 6 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2412 Mayfield Ave 8-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	21 Jan 1949	0	— / 6	— / —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn (Premature)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME James Gardner
14. MOTHER'S MAIDEN NAME Elizabeth LaFon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Hospital Records ADDRESS Mercy Hosp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral Broncho-pneumonia — Interval between onset and death: 12 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Atelectasis — 12 hours

DUE TO

(C) Prematurity — 6 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 21 Jan, 1949 *to* 27 Jan, 1949 *that I last saw the deceased alive on* 27 Jan, 1949, *and that death occurred at* 6:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE A. M. Bacon Jr M. D.
23B. ADDRESS Mercy Hospital
23C. DATE SIGNED 27 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Jan 29-49
24C. NAME OF CEMETERY OR CREMATORY St Patricks
24D. LOCATION (City, town, or county) (State) Hinton W. Va

DATE RECEIVED BY LOCAL REGISTRAR JAN 28 1949
REGISTRAR'S SIGNATURE Huntington West Virginia
25. FUNERAL DIRECTOR Jos J Herr & Son
ADDRESS 3001 Kentucky Ave

VS 150

159

If any items are unknown, write UNKNOWN. Every item of information should be carefully supplied. Correct age is especially important. Physician please write the cause of death clearly and legibly.

G70998 ✓ 420.1 G70998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) CHARLES JOHNSON

2. DATE OF DEATH January 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S. Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore 48 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 923 Sharp St. 23-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	ool	Single	Apr. 1, 1884	64	9 23	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman	Seafarer	Elizabeth City, NC	USA

13. FATHER'S NAME Charles Johnson

14. MOTHER'S MAIDEN NAME Lizzie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
Unknown	?	Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) 1- Myocardial infarction, coronary sclerosis — Interval between onset and death: Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) 2- Hemorrhage, nasopharynx, profuse — 6 days

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 18 1949 *to* Jan. 24, 1949, *that I last saw the deceased alive on* Jan. 24 1949, *and that death occurred at* 10:25A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Wilson, Sr. Surgeon M.D.	US Marine Hospital, Balto, Md.	1/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 28, 1949	Mt Calvary	Anne Arundel Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 28 1949	Huntington for Williams, M.D.	Mrs Kate R. Williams Schroeder & 3224

VS 150

94a

If this WHITE PAPER is soiled, with ONE DOG INK. Every item of information should be correctly supplied, correct age is especially important. Physician please write the cause of death clearly and legibly.

G70999

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

331

G70999

Reg. Dist. No. .....

1. PLACE OF DEATH:

County .....

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: 6211 Pennington Ave

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6211 Pennington Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Julia A. Smith

3.(b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Willis Smith Sr.

6.(c) If alive, give age ..... years

7. Date of birth of deceased (mo., day, yr.) March 27, 1882

8. AGE:	Years	Months	Days	If less than one day
	66	9	28	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER — 12. Name Adam Ross

13. Birthplace Ireland

MOTHER — 14. Maiden name Margaret

15. Birthplace Ireland

16. Informant Mr. Willis Smith

Address 6211 Pennignton Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 29, 1949 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Ritchie Highway

18. Funeral director Harry N. Ristato

Address 401 E Monument Ave

19. JAN 28 1949 (Date rec'd by registrar) 19. Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 26 19 49, at 12:12 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 49 to Jan 26 19 49 and that I last saw her alive on Jan. 25 19 49

Immediate cause of death Heart Failure — DURATION .....

Due to Cerebral Hemorrhage — 1 year

Due to Hypertension — 3 years

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Brady Smith, M.D. M. D. or other

Address Riviera Beach, Md. Date signed 1/26/49

(2) 1000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. G71000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 S. Loudon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 S. Loudon Ave. 20-8
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl G. Latchford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John D. Latchford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 28, 1884

8. AGE: Years	Months	Days	If less than one day
64	5	27	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Wise
13. Birthplace Missouri

MOTHER
14. Maiden Name Emma Marsh
15. Birthplace Md.

16 (a) Informant Mr John D. Latchford
(b) Address 211 S. Loudon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29 '49 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Harry H. Sitzler
(b) Address 4101 Edmondson Ave

19 JAN 28 1949 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1949 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-1 1947 to Jan-25 1949 and that I last saw her alive on Jan-25 1949.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 dys.
Due to Arterial Hypertension	2 yrs.
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ?
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. Lloyd Johnson M. D.
Address Catonsville, Md. Date signed 1/27/49

VS 150

83a

(37)1001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1 G71001 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 S. Gilmore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. Gilmore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland E Berlin (Berline)

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 218-10-3732

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Phoebe R(North)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1898

8. AGE: Years 50 | Months 11 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Operator

11. Industry or business Baltimore Transit Co.

FATHER
12. Name George A. Berlin
13. Birthplace

MOTHER
14. Maiden Name Louise
15. Birthplace

16 (a) Informant Mrs Roland E. Berlin
(b) Address 125 S. Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29'49 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore, Md.

18 (a) Funeral director Harry A Wetzler
(b) Address 401 Edmondson Ave

19 (a) JAN 28 1949 (Date rec'd by registrar) (b) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 26 1949, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1949 to Jan 26 1949, and that I last saw him alive on Jan. 24 1949.

Immediate cause of death: Myocardial infarction, Coronary thrombosis — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. B. Schreiber M. D.
Address 6 Y S. Fulton Ave Date signed 1-27-49

VS 150

94a

G71002 ✓443 G71002

BALTIMORE CITY HEALTH DEPARTMENT 451 Registered No.

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sandy Jefferson

2. DATE OF DEATH: 1-27-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-1

D. STREET ADDRESS (If rural, give location): 837 West Fayette Str

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Widowed	?	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None -	None	Virginia	USA -

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Unknown -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Sister - Rosey Taylor	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dissecting aneurysm-aorta — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio vascular disease — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 days -

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None -		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-25, 1949 *to* 1-27, 1949, *that I last saw the deceased alive on* 1-27, 1949, *and that death occurred at* 8:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Evans Jr - M. D.	University Hospital	1-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 1 1949	Mt Calvary	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams, MD	W. Halstead -	918 Druid Hill Ave. 20

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physician: please write the cause of death clearly and correct age is especially important.

G71003

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

42031 / 163

G71003

Registered No.

1. NAME OF DECEASED (Type or Print): SAMUEL LOUIS WALDSCHMIDT

2. DATE OF DEATH: Jan. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 328 S. Augusta Avenue

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 328 S. Augusta Avenue 20-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Nov. 10, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chief Clerk	B. & O. R.R. Co.	Baltimore, Maryland	USA

13. FATHER'S NAME: Charles Waldschmidt

14. MOTHER'S MAIDEN NAME: Mary Hupp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT
No	705-05-2979	Mrs. J. Amanda Waldschmidt- 328 S. Augusta Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 28 days

DUE TO

(B) Arteriosclerosis —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Bronchogenic Carcinoma (rt)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 5, 1948 *to* Jan 26, 1949, *that I last saw the deceased alive on* Jan 26, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
J. M. Collins	3321 Frederick Ave	1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/28/49	Loudon Park Cemetery	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 28 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC. BALTIMORE, MARYLAND

VS 150

47c

PLEASE WRITE PLAINLY, WITH [illegible] correct age is especially important. Physician: please write the cause of death clearly and [illegible]

G71004

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170
199.9 G71004
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LILLIAN W. BRETALL

2. DATE OF DEATH Jan. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1519 E. 28th. Street

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1519 E. 28th. Street 9-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	Jan. 28, 1893	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CHARLES W. IRWIN	ANNA WEATHER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	None	Mr. Christian W. Bretall	1519 E. 28th Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma of liver, spine, and brain

DUE TO

(B) Carcinoma of Breast

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION June 1947.

19B. MAJOR FINDINGS OF OPERATION Carcinoma of breast

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1947 *to* Jany 26, 1949, *that I last saw the deceased alive on* 1/25/49, *and that death occurred at* 1.45 a m., *from the causes and on the date stated above.*

23A. SIGNATURE Hoole a Bandeen M. D.

23B. ADDRESS 303 Med Arts Bldg

23C. DATE SIGNED 1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1/29/49

24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR JAN 28 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.

VS 150

BALTIMORE, MARYLAND

50

PLEASE WRITE PLAINLY with ... correct age is especially important. Physician: please write the cause ... of death clearly and ...

G71005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

2 14 954

G71005

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ELLA BOND

2. DATE OF DEATH Jan. 25 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-2
D. STREET ADDRESS (If rural, give location) 1718 McKean Ave

5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 5-15 91
9. AGE (In years last birthday) 57 If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) No. Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Ellis Wynn
14. MOTHER'S MAIDEN NAME Annie Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis ? — INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Anesthetic during operation for myoma uterus

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Myoma uterus.

CERTIFICATION APPROVED BY
for: Wm. G. Reichm.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION Jan 25 1949
19B. MAJOR FINDINGS OF OPERATION Myoma uterus
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Johns Hopkins Hospital
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Broadway and Monument St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 1 25 49 1p.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Anesthetic death

22. *I hereby certify that I attended the deceased from* 1/11, 1949 *to* 1/25, 1949, *that I last saw the deceased alive on* 1/25, 1949, *and that death occurred at* 1 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE John Watt, Jr. M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) 1-28-49
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY Mt Auburn.
24D. LOCATION (City, town, or county) (State) md

DATE RECEIVED BY LOCAL REGISTRAR JAN 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR George D. Nelson
ADDRESS 723 Fairmount

VS 150

56B 85

PLEASE WRITE PLAINLY. Physician: please write the cause of death clearly and correct age is especially important.

G71006 ✓ 085.0 G71006

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C.H-93725 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): Johnathan Alfred

2. DATE OF DEATH: 1/27/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Sydenham Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sydenham Hospital

c. Length of stay in Baltimore: 14 mo. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3430 Ash Street 13+F

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH: 11/12/47

9. AGE (In years last birthday) If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.: 1 year

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA ✓

13. FATHER'S NAME: Ralph Alfred

14. MOTHER'S MAIDEN NAME: Hazel Whitehead

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO: —

17. INFORMANT: Mother — ADDRESS: 3430 Ash Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Encephalitis
DUE TO
(B) Measles
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 WKS

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION: 0

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): 0

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): 0

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 0

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 0 m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR? 0

22. *I hereby certify that I attended the deceased from* 1/13, 1949 *to* 1/27, 1949 *that I last saw the deceased alive on* 1/27, 1949, *and that death occurred at* 7:55 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul Baxter M. D.

23B. ADDRESS: Sydenham Hospital

23C. DATE SIGNED: 1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/29/49

24C. NAME OF CEMETERY OR CREMATORY: St Marys

24D. LOCATION (City, town, or county) (State): Hampden.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Paul E. Clemonts Jr. ADDRESS: 345-17 Greenmount Ave

VS 150

PLEASE WRITE PLAINLY, WITH PEN ... correct age is especially important. Physician: please write the cause of death clearly and legibly.

35

G71007 ✓ 570.1 G71007

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Maude Lula Dean

2. DATE OF DEATH: Jan 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hosp.

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1201 W. Cross St. 21-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	10/19/1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore Md.	

13. FATHER'S NAME: Unknown Hartman

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Anna Ambrose 1328 Saratoga St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Paralytic ileus

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive Cardio Vascular Disease
Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 21, 1949, *to* Jan 27, 1949, *that I last saw the deceased alive on* Jan 27, 1949 *and that death occurred at* 6:45 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. C. Reasons Jr. M. D.	St. Agnes Hosp.	Jan 27/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/31/49	Mt. Olivet	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Thomas Williams M.D.	Joseph T. Timanus Jr.	93D

VS 150

PLEASE WRITE CLEARLY with pen and ink: Physician: please write the cause of death in plain words. Do not use abbreviations or symbols. Be sure to answer all questions. Underlying cause of death is especially important. Physician: please write the cause of death in plain words. Do not use abbreviations or symbols. Be sure to answer all questions. Underlying cause of death is especially important.

G71008 ✓ 334 G71008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna D. Herford

2. DATE OF DEATH: Jan. 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2531 Guilford Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 2531 Guilford Ave., 12-3

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Nov.25,1874
9. AGE (In years last birthday): 74 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Moyland
14. MOTHER'S MAIDEN NAME: Catherine Tuitt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ---
17. INFORMANT — ADDRESS: Mrs. M. Callahan, 2531 Guilford Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Apoplexy	4 hrs.
DUE TO	Generalized Arteriosclerosis	years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 1 48, to 1/27, 19 49, *that I last saw the deceased alive on* 1/27 19 49, *and that death occurred at* 3:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 3 West Biddle St.
23C. DATE SIGNED: 1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/29/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949
REGISTRAR'S SIGNATURE: [signature] for Williams, M.D.
FUNERAL DIRECTOR: La Vernon Lemmon
ADDRESS: 4611 Park Heights.

VS 150

PLEASE WRITE LEGIBLY. Physician: please write the cause of death clearly and correct age is especially important.

83a

B.C.H-77447

G71009 ✓ 491 G71009

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Gordon E. Kramer Jr. — 2. DATE OF DEATH 1/28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1214 Glyndon Ave

c. Length of stay in Baltimore 2 Yrs. 9 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore — D. STREET ADDRESS (If rural, give location) 1214 Glyndon Ave 21-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Single	4/26/49	0yr		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
none	✓	Maryland	USA ✓

13. FATHER'S NAME Gordon E. Kramer — 14. MOTHER'S MAIDEN NAME Dorothy L. Zill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
✓	✓	✓	Mrs Gordon E. Kramer	1214 Glyndon Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — DUE TO — INTERVAL BETWEEN ONSET AND DEATH 4-5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-27-49, 19__ *to* 1-28-49, 19__, *that I last saw the deceased alive on* 1-27-49, *and that death occurred at* 6:00 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[illegible] M. D.	642 Wash. Blvd	1-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/31/49	Baltimore Cem.	E North Ave + Rose St

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams, M.D.	John J. Cowan + Son	90 Hollins St

VS 150

PLEASE WRITE PLAINLY, with pencil or pen. Physician please write the cause of death exactly and correct age is especially important.

107

7410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

587.0 G7410

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) [redacted], PAUL PARDO

2. DATE OF DEATH Jan 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore Gen Hosp

c. Length of stay in Baltimore 40 Yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3606 East Pratt 26-8

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH June 8 1879

9. AGE (In years last birthday) 69
If Under 1 Year: Months 7 Days 19
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Salvatore Pardo

14. MOTHER'S MAIDEN NAME Rosa Tuttobene

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Hemorrhagic Pan — DUE TO cretitis — Interval between onset and death: 2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION Jan 26, 1949

19B. MAJOR FINDINGS OF OPERATION Acute Hemorrhagic Pancreatitis

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 25, 1949, *to* Jan 27, 1949 *that I last saw the deceased alive on* Jan 27, 1949, *and that death occurred at* 12 30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE John M. Beyer Jr M. D.

23B. ADDRESS South Balt Gen Hosp

23C. DATE SIGNED Jan 27 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Jan. 31 1949

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town, or county) (State) Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 28 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR ADDRESS Frank Wells Hoel 322 S. High St.

VS 150

PLEASE WRITE PLAINLY. Physician: please write the cause of death in terms of disease and not in terms of mode of dying, such as heart failure, asthenia, anemia, or uremia. Correct age is especially important.

128

G.H. 126349 G71011 420.1 G71017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William H. Maxwell

2. DATE OF DEATH 1- 27- 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 30 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3928 Reisterstown RD. 15-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	Oct. 27 1879	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Elevator Operator	Y. M. C. A.	PA. (Layton)	

13. FATHER'S NAME S. Joseph Maxwell

14. MOTHER'S MAIDEN NAME Emma Faidley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
no	215-07-5464	Records Balto. City Hospitals 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infraction — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Conoary Arbery Disease — DUE TO

(C) — DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 Days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1- 25- , 1949 *to* 1- 27- , 1949, *that I last saw the deceased alive on* 1- 27- 1949 *and that death occurred at* 7.00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. L. Cozzens M. D.	B.C.H. 4940 Eastern Ave.	1-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1/29/49	Rose Hill Cem.	Cumberland, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams M.D.	WM. J. TICKNER & SONS	Balto., Md.

PLEASE WRITE PLAINLY, with ink. Physician: please write the cause of death clearly and correct age is especially important.

94a

G71012 ✓ 442 G71012

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): LEWIS GIBSON
2. DATE OF DEATH: Jan 27 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore
4. USUAL RESIDENCE: A. STATE Md B. COUNTY (Where deceased lived. If institution: residence before admission)

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 818 N. Wolfe St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)
D. STREET ADDRESS (If rural, give location): 818 N. Wolfe St 7-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	Col	Widowed	Mar 13-1868	80		

10A. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Long Shoreman		Baltimore	

13. FATHER'S NAME: George Gipson
14. MOTHER'S MAIDEN NAME: Mary Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Unknown		Mrs Lulu Downey	818 N Wolfe St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Renal Disease

DUE TO

(B) Cardio-Renal Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-2-, 1949 *to* 1-27-, 1949, *that I last saw the deceased alive on* 1-26-, 1949, *and that death occurred at* 1 A. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jos. H. Cargill M. D.	611 N. Caroline St	1-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-30-49	Laurel Em.	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams, MD	Rayner Sanders	1412 E Preston St

VS 150

PLEASE WRITE PLAINLY. Physician: please write the cause of death correct age is especially important.

1210

G71013 ✓ X 002 179 G71013

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1949

1. NAME OF DECEASED (Type or Print): LEON BOSTON

2. DATE OF DEATH: Jan. 27, 1948

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Annapolis
D. STREET ADDRESS (If rural, give location): 314 Chester St. Eastport

5. SEX: male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Sept.
8. DATE OF BIRTH: 4-30-12
9. AGE (In years last birthday): 36 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard Boston
14. MOTHER'S MAIDEN NAME: Ethel Rawlings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous pneumonia.
DUE TO
(B) Pulmonary tuberculosis.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Carcinoma of Penis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/26, 1949 *to* 1/27, 1949, *that I last saw the deceased alive on* 1/27, 1949, *and that death occurred at* 7:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Evan Calkins
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/30/49
24C. NAME OF CEMETERY OR CREMATORY: Fowlers Chapel
24D. LOCATION (City, town, or county) (State): Bel Air Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949
REGISTRAR'S SIGNATURE: Timothy Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Wm. Chas. E. Wichs Annapolis, Md.

VS 150

PLEASE WRITE PLAINLY, WITH ... correct age is especially important. Physician: please write the cause of death clearly and ...

7104 ✓ 584 G7104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Milanowski
2. DATE OF DEATH: 1-26-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.
c. Length of stay in Baltimore: 50 yrs. (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balt.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. 7-1
D. STREET ADDRESS (If rural, give location): 4009 N Woodlea Ave
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: ? 1877
9. AGE (In years last birthday): 71 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sailor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lith
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: J. Milanowski
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: ?
17. INFORMANT: Mrs Nellie Milanowski ADDRESS: 4009 Woodlea Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia
DUE TO
(B) Cholelithiasis c Postoperative wound evisceration of pseudocyst
DUE TO
(C) Hepato-renal syndrome

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Dec 29, 1948
19B. MAJOR FINDINGS OF OPERATION: Cholelithiasis
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 28, 1948 *to* Jan 26, 1949, *that I last saw the deceased alive on* Jan 26, 1949, *and that death occurred at* 10 30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: K. Y. Swisher Jr. M. D.
23B. ADDRESS: Univ. Hosp.
23C. DATE SIGNED: 1-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: JAN 29-1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Rd Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Joseph Kaminskas Jr. ADDRESS: 602 Wash

VS 150

126 Balt.

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Be sure that every item is correct and complete: please write the cause of death clearly and accurately. Physician: please write the cause of death clearly and accurately. Physician: please write the cause of death clearly and accurately. Physician

G71015 ✓ 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No. G71015

1. NAME OF DECEASED (Type or Print) ANNA SIMANAITIS

2. DATE OF DEATH JAN 27-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1348 Glydon Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 42 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 1348 Glydon Ave 21-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed	7 1887	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (State or foreign country) Lith.
12. CITIZEN OF WHAT COUNTRY? ?
13. FATHER'S NAME Anthony
14. MOTHER'S MAIDEN NAME ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes give war or dates of service) —
16. SOCIAL SECURITY NO —
17. INFORMANT Joseph Simenaitis ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Generalized Arteriosclerosis
DUE TO

(C) —

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

INTERVAL BETWEEN ONSET AND DEATH 5-6 yr

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur? —

22. I hereby certify that I attended the deceased from June 1948 to Jan 27, 1949 that I last saw the deceased alive on Jan 26, 1949 and that death occurred at 4.2 m., from the causes and on the date stated above.

23A. SIGNATURE [signature] M. D.
23B. ADDRESS 642 Wash. Blvd
23C. DATE SIGNED 1-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE 1/29/49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) (State) Blair Rd md

DATE RECEIVED BY LOCAL REGISTRAR JAN 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Joseph Kasmakas Inc ADDRESS 94a 602 Wash. Blvd

VS 150

PLEASE WRITE CLEARLY and correct age is especially important. Physician: please write the cause of death in terms

✓ 416

G71016

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71016

Registered No.

1. NAME OF DECEASED (Type or Print): Vincent J.Ritz

2. DATE OF DEATH: Jan.28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2228 E.Hoffman St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 2228 E.Hoffman St. 8-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	May 22,1926	22	7 / 28	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
--	---	Balto. Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Geo. Ritz	Mary King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
--	---	----	Mrs.Mary Ritz	2228 E.Hoffman St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic C. V. D — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Broncho pneumonia — 2-3 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/24, 1948 *to* 1/28, 1949 *that I last saw the deceased alive on* 1/27, 1949 *and that death occurred at* 1 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Karl Hressman M. D.	1212 N. Patterson Park	1/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 31/49	Balto. Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Huntington Williams M.D.	Philip Newirth	1024 Orleans St

VS 150

95 B

Please write plainly; use ink. Be sure that every important, applicable item is correctly answered. Physician: please write the cause of death in such a way that the correct age is especially important.

AB-126382

BIRTH NO. G71017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.0 G71017 Registered No.

1. NAME OF DECEASED (Type or Print): William Edward Anderson

2. DATE OF DEATH: Jan. 26-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
4940 Eastern Avenue

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1107 Park Avenue 11-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
M	W	Single	Aug. 13-1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ross Anderson (D	Sophie (D ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Baltimore City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARTERIOSCLEROTIC HEART DISEASE — ?

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NONE		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-26-, 1949 *to* 1-26-, 1949, *that I last saw the deceased alive on* 1-26-, 1949, *and that death occurred at* 10:55 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas P. Jennings M. D.	BALTIMORE CITY HOSPITALS	1-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/31/49	Woodlawn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington for Williams M.D.	Chas. J. Evans & Son, Inc.	1182 W. Mt. Royal Ave. 93

PLEASE WRITE LEGIBLY. Physician: please write the cause of death in terms of disease and correct age is especially important.

G71018 ✓572.3 G71018

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Henrietta Lambe

2. DATE OF DEATH: January 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Avon Apts.,6 E.Read St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

C. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Avon Apts., 6 E. Read St. 11-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	12/17/51	97		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Centreville, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Lambe

14. MOTHER'S MAIDEN NAME: Rebecca Roe ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Sadie A. Roe ADDRESS: 6 E. Read St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypostatic Pneumonia	10 days
DUE TO (B)	Chronic Colitis	3 months
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Senility	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JAN. 19, 1949, *to* JAN. 27, 1949 *that I last saw the deceased alive on* JAN. 26, 1949, *and that death occurred at* 6:50 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: W. Hoffman M. D. M. D.

23B. ADDRESS: 8 East Read St. (2)

23C. DATE SIGNED: 1/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/29/49

24C. NAME OF CEMETERY OR CREMATORY: Chesterfield

24D. LOCATION (City, town, or county) (State): Centerville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Place

Mitchell & Mitchell

1209

VS 150

Please write this card carefully. Physician: please write this card carefully. Be especially important. Physician: please write this card carefully. Be especially important. Exact age is especially important.

71019 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 422.1

G71019 Registered No.

1. NAME OF DECEASED (Type or Print): John F. Bibleheiser

2. DATE OF DEATH: Jan. 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1617 Eutaw Place

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1617 Eutaw Place 14-1

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 5/9/81
9. AGE (In years last birthday): 67 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Francis Bibleheiser

14. MOTHER'S MAIDEN NAME: Ellen Morrow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Mary B. Lilly ADDRESS: 3034 Belmont Ave.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho pneumonia (Hypostatic). — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiac Insufficiency & Decompensation. — about 1 year
DUE TO Arteriosclerotic Cardio Vascular Disease — years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Atherosis, Anitamiosis, Eczema.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 21 Jan, 1949, to 26 Jan, 1949, *that I last saw the deceased alive on* 26 Jan, 1949, *and that death occurred at* 7:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lamston L. Brown M.D.
23B. ADDRESS: 1538 Linden Ave
23C. DATE SIGNED: 27 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/29/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John J. Mitchell & Sons, Inc.- ADDRESS: 1900 Eutaw Pl.

Mahlon B. Mitchell 93D

VS 150

Please write in ink. Physician: please write the cause of death in such a manner that it may be easily read. Be sure that the correct age is especially important. Physician: please write the cause of death in such a manner that it may be easily read.

71020 ✓ + 163 177 G71020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): AUGUSTUS C. BAKER

2. DATE OF DEATH: Jan. 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. _ Mos. 1 Days mo. 2 dys.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Frederick
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Woodsboro
D. STREET ADDRESS (If rural, give location): -

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	June 25, 1869	79	-	-		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Retired	Frederick Co., Md.	U. S. A.

13. FATHER'S NAME: Nathan Baker

14. MOTHER'S MAIDEN NAME: Elizabeth Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		-	N. T. Baker	Woodsboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 20 min.

DUE TO

(B) Phlebothrombosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Carcinoma of Prostate

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
JAN 10, 1949	Enlarged Prostate	YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 4, 1949 *to* Jan. 25, 1949, *that I last saw the deceased alive on* Jan. 25, 1949, *and that death occurred at* 3:30P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Auld M. D.	University Hospital	Jan. 25, '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 29, '49	Mt. Hope Cemetery	Woodsboro, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Tunstington for Williams, M.D.	Powell & Hartzler	Woodsboro, Md.

VS 150

51B

PLEASE WRITE CLEARLY — correct age is especially important. Physician: please write the cause of death

G7.1021 ✓ 422.1 G7.1021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas J. White

2. DATE OF DEATH: 26 Jan. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 146 N. Curley St.

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-1
D. STREET ADDRESS (If rural, give location) 146 N. Curley St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Widowed	Oct. 20, 1871	77 78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Maryland	

13. FATHER'S NAME: John E. White

14. MOTHER'S MAIDEN NAME: ? Barnett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Joseph White. 35 N. Potomac St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Wm. H. Kammer, Jr. M.D.		27 Jan. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-31-49	Holy Redeemer	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 28 1949	Huntington Williams, M.D.	John A. Moran

PLEASE WRITE PLAINLY, with pen and ink; please write the cause of death carefully and correct age is especially important. Physician: please write the cause of death carefully and correct age is especially important.

S 151

93D

G71022

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

2044 G71022

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Esther Firkser

2. DATE OF DEATH 1/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai

c. Length of stay in Baltimore 2½ Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-20
D. STREET ADDRESS (If rural, give location) 4003 Fordleigh Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year: If under 1 month: If under 24 hours: Hours: Min.)
Female	White	Married		38

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife		New York	

13. FATHER'S NAME Carl Rothman

14. MOTHER'S MAIDEN NAME Cynie Senger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Sidney Firkser 4003 Fordleigh Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Leukemia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH: 1 year

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/20, 1949, *to* 1/28, 1949, *that I last saw the deceased alive on* 1/27, 1949, *and that death occurred at* 2:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David V. Berlin M. D.	Sinai Hospital	1/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-30-49	Beth David	New York N Y

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

74a

PLEASE WRITE CLEARLY — Important. Physician: please write the cause of death clearly, correct age is especially important.

671023

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.2 671023

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RICHARD DUVALL

2. DATE OF DEATH: January 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 604 West Redwood Street 4-2

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
male	white	U	U	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	K		

13. FATHER'S NAME: U

14. MOTHER'S MAIDEN NAME: U

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	N		

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myocardial degeneration	
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L. Royster M.D.		January 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	JAN 26 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 28 1949	Huntington Williams, M.D.	Commissioner of Health	

PLEASE WRITE PLAINLY, with pen and ink; please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 151

93

G71024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

340.1

Registered No. G71024

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RICHARD E. HARMAN

2. DATE OF DEATH: Jan. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL

C. Length of stay in Baltimore: 7 Yrs. / 1 Mos. / 6 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): TANEYTOWN
D. STREET ADDRESS (If rural, give location): ROUTE 1-M

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	WHITE	SINGLE	12/21/48		1 / 6	— / —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: GEORGE HARMAN
14. MOTHER'S MAIDEN NAME: JEAN MONNEY
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO:
17. INFORMANT: PATIENTS HOSPITAL CHART — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) MENINGITIS, PURULENT, ACUTE — INTERVAL BETWEEN ONSET AND DEATH: 1-5 days
DUE TO
(B) PROBABLY PNEUMOCOCCUS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: THROMBOSIS - SUPERIOR SAGITTAL SINUS

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?: —

22. I hereby certify that I attended the deceased from Jan 26 1949 to Jan 28, 1949 that I last saw the deceased alive on Jan 28, 1949, and that death occurred at 7:45 A m., from the causes and on the date stated above.

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): —
24B. DATE: Jan 30/49
24C. NAME OF CEMETERY OR CREMATORY: St Marys Cemetery
24D. LOCATION (City, town, or county) (State): Silver Run Carroll Co.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 29 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR — ADDRESS: Harry H. Witzke-4101 Edmondson Ave.

VS 150

1048

PLEASE WRITE CLEARLY — use pen and correct age is especially important. Physician: please write the cause of death clearly.

25 ✓ 420.1

G71025
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71025
Registered No.

1. NAME OF DECEASED (Type or Print): BERTIE AUGUSTA KATHERINE TARBOROUGH

2. DATE OF DEATH: 1/28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Women's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Baltimore AN Apts. #206

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	June 6, 1885	63	7 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wilmington, N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Louis Hanson
14. MOTHER'S MAIDEN NAME: Augusta A Glamoyn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Wm C Tarborough ADDRESS: 2902 W Cold St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardinal Infarct
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* JAN. 27, 1949 *to* JAN. 28, 1949 *that I last saw the deceased alive on* JAN 27, 1949, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. C. Decker M. D.
23B. ADDRESS: Women's Hospital
23C. DATE SIGNED: 1-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/29/49.
24C. NAME OF CEMETERY OR CREMATORY: Oakdale
24D. LOCATION (City, town, or county) (State): Wilmington N C
DATE RECEIVED BY LOCAL REGISTRAR: JAN 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Fulton & Son Inc ADDRESS: 127 N Pond St

VS 150

942

G71026

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

26 416 G71026

Registered No.

1. NAME OF DECEASED (Type or Print): LOUIS EDWIN LOYD

2. DATE OF DEATH: 1-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: Yrs. — Mos. — Days —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brooklyn
D. STREET ADDRESS (If rural, give location): 1 Church St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W	S	1-26-24	25 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Loyd

14. MOTHER'S MAIDEN NAME: Sarah Hise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 229-24-2574

17. INFORMANT: Patient - history
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic heart disease
DUE TO Subacute bacterial Endocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-11 1949 *to* 1-26 1949 *that I last saw the deceased alive on* 1-26 1949 *and that death occurred at* 11:20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: James McC. Finney M. D.

23B. ADDRESS: Union Memorial Hospital

23C. DATE SIGNED: 1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/29/49

24C. NAME OF CEMETERY OR CREMATORY: Mt Solon

24D. LOCATION (City, town, or county) (State): Mt Solon Va

DATE RECEIVED BY LOCAL REGISTRAR: JAN 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wilborn Corbin

ADDRESS: 219 E Broad St

VS 150

95B

G71027 420.0

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71027

1. NAME OF DECEASED (Type or Print): Andrew Miller

2. DATE OF DEATH: 1/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1516 N. Luzerne Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: 1749 N. Lebester
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1749 N. Lebester St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Widowed	[illegible] Dec 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed		Md	

13. FATHER'S NAME: John Miller

14. MOTHER'S MAIDEN NAME: Katie Remmert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Charles Lename	1749 Lebester St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease — Interval between onset and death: 1 yr.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/31 1948 *to* 1/27 1949 *that I last saw the deceased alive on* 1/11 1949 *and that death occurred at* 2:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Conrad L. Rutter M. D.	1706 N Wash. St	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 29th 1949	Baltchem	E. North Ave East

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Huntington Williams, Jr.	Geo. G. Leach	1703 N. Patterson Park Ave

05 150

937

G71028 ✓ 420.1 G71028

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mary B. Lloyd

2. DATE OF DEATH: Jan. 28th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3810 Pinewood Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 43 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3810 Pinewood Ave. 27-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	married	Jan. 19th, 1866	83		11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Md.	

13. FATHER'S NAME: Conrad Stengel

14. MOTHER'S MAIDEN NAME: Kunigunda Botterwich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. Edwin A. Lloyd	3810 Pinewood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CORONARY ARTERY THROMBOSIS	3 DAYS
DUE TO (B)	CORONARY ARTERIOSCLEROSIS	2 YRS ±
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	—	—
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	SENILITY	—

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—		

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JAN. 25, 1949 *to* JAN. 28, 1949, *that I last saw the deceased alive on* JAN. 27, 19 49 *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	6331 Belair Road (6)	1/28/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1/31/49	Baltimore	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Huntington Williams, M.D.	Lasacks Funeral Home	7201 Belair Rd.

VS 150

94a

G71029

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1 G71029 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry W. Carter

2. DATE OF DEATH: Jan. 28th, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 4206 Valley View Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 4206 Valley View Ave. 76-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	June 13th, 1890	58	7	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Paper Cutter	Printer	Baltimore County, Md.	

13. FATHER'S NAME: William H. Carter

14. MOTHER'S MAIDEN NAME: Emma V. Evans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. William Carter	4009 Glenarm Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: many years.

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis — many years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 18, 1949, *to* Jan 28, 1949, *that I last saw the deceased alive on* Jan 27, 1949, *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Max R. English M. D.	5713 Belair Rd.	1-28-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1/31/49	Prospect Hill	Towson, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Huntington Williams, M.D.	Lassahn Funeral Home	7401 Belair Rd.

VS 150

94a

G71039 Vol 7

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

456 592 G71030
Registered No.

1. NAME OF DECEASED (Type or Print): Hazel Taylor

2. DATE OF DEATH: JAN 27 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14; D. STREET ADDRESS (If rural, give location) 2010 Druid Hill Ave

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 45 Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	10-8-03	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Md	

13. FATHER'S NAME: Henry Ridgley

14. MOTHER'S MAIDEN NAME: Marceline Demby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A)	Resp. depression	3 days.
DUE TO (B)	Uremia	1 mo
DUE TO (C)	Chr nephritis — Disseminated Lupus Erythematosis.	6 mos.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-24-, 1949 to 1-27-, 1949 that I last saw the deceased alive on 1-27-, 1949 and that death occurred at 6 00 a.m., from the causes and on the date stated above.

23A. SIGNATURE: Jon Colburn, M. D. | 23B. ADDRESS: JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Jan-30-1949 | 24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem | 24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 29 1949

REGISTRAR'S SIGNATURE: Emily Jane Williams, M.D.

25. FUNERAL DIRECTOR: Mrs. Frances A. Kennedy | ADDRESS: 518 E. Biddle St.

VS 150

8

13 1a

Please write the cause of death in the space provided. Be sure age is especially important. Physician: please write the cause of death in the space provided. Be sure age is especially important.

G71031

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

981.5 E 86 N

G71031 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William (Cannady) Canady

2. DATE OF DEATH: 1/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Universtiy Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 509 S. Green St. 22-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	C	Single	Nov. 6, 1927	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Laborer	North Carolina	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Elnire Canady

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	708-07-5081	Roosevelt Canaday	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet wound of

DUE TO

(B) Heart.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Public	Green & Conway Sts.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
1 26 49 7:30P	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Emil L. Beyer M.D.	[ ] / [X] / [ ]	1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	February 1, 1949	St Mary Cemetery	Rock Hill, York South Carolina

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Thurston Williams, M.D.	Joseph A. Sisly	661 West Baare Street

VS 451

166

Please write plainly, correct age is especially important. Physician, please write the cause of death clearly and fully.

G71032 ✓ 420.1 G71032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANK LE GRAND CARLIN

2. DATE OF DEATH: Jan. 27 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2702 Guilford ave
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2702 Guilford ave 17 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Single	July 13 1874	74	6	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	U.S.F.+G. Co.	Balto. Md.	✓

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Carlin	Mary Deane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Spanish American	✓	Mrs Mae Carlin Res	2702 Guilford ave

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — (INTERVAL BETWEEN ONSET AND DEATH) 15 min.
DUE TO
(B) Arteriosclerosis
DUE TO
(C) old age.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1940, *to* Jan 27, 1949, *that I last saw the deceased alive on* Jan 26, 1949, *and that death occurred at* 3.45 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward L. Mortimer Jr. M. D.	2706 St Paul St	1/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 31 1949	New Cathedral	Balto., Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Evelyn Jr. Williams, M.D.	Henry Jenkins Sons Co	4905 Oak Rd

VS 150

942

G71033
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1

G71033
Registered No.

1. NAME OF DECEASED (Type or Print): Mr. James L. Gruntkowski

2. DATE OF DEATH: January 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: 61 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 435 S. Robinson Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Oct. 27, 1887	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Works for Terminal Warehouse

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Gruntkowski

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 212-10-5515

17. INFORMANT: Mrs. Frances Gruntkowski ADDRESS: 435 S. Robinson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure
DUE TO
(B) Cardiac decompensation
DUE TO
(C) Coronary occlusion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan 27, 1949, *to* Jan 28, 1949, *that I last saw the deceased alive on* Jan 28, 1949, *and that death occurred at* 3 22 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Philip A. Pratt M.D.

23B. ADDRESS: 1400 N. Caroline Street

23C. DATE SIGNED: 1/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-31-49

24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 29 1949

REGISTRAR'S SIGNATURE: Evelyn J. Williams

25. FUNERAL DIRECTOR: George A. Weber ADDRESS: 705-30 Aisquith St

VS 150

95c

Please write in the ... Physician ... important. ... especially ... correct age is especial

G71034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1

Registered No. G71034

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 SOUTH ANN ST
(c) Hospital or institution: HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 So. ANN ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN RAWINISZ

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-2103

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of wife Catherine
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept, 20-1886

8. AGE: Years	Months	Days	If less than one day
62	4	8	..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Vincent Rawinisz
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna Pieczkowski
15. Birthplace Poland

16 (a) Informant Mrs. Catherine Rawinisz
(b) Address 511 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-49 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street.

19 (a) JAN 29 1949 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28th 1949, at 10:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1948 to Jan. 28 1949, and that I last saw him alive on Jan. 22 1949.

Immediate cause of death	Duration
Congestive Heart failure	1 wk.
Due to Coronary thrombosis	1 yr.
Due to Cardiac hypertrophy	1 yr.
Other Conditions Left bundle branch block.	1 year

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph Drozd M.D.
Address 2601 Eastern Ave Date signed 28 Jan. 49

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

94a

G71035 ✓ 163 G71035

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): EMANUEL DIAKOGIANIS

2. DATE OF DEATH: 1/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 506 South Aldham St. 26-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months Days	If under 24 Hours: Hours Min.
Male	White	Married	6/16/1897	51 52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Builder		Greece	

13. FATHER'S NAME: Steve

14. MOTHER'S MAIDEN NAME: Maryasie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Lung, Rt. — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cachexia

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2-11-48	Carcinoma of Lung, Rt., Inoperable	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 20, 1948 *to* Jan. 27, 1949 *that I last saw the deceased alive on* Jan 27, 1949 *and that death occurred at* 10 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James N. Evans M. D.	1225 N. Calvert St.	1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-29-49	Greek Cemetery	Windsor Mill Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 29 1949	Henrietta Williams, M.D.	Lambros Inc 444 E. North Ave.

VS 150

477

Physician: please write the cause of death in such a manner that the correct age is especially important.

484277

G71036 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ X 177 G71036 Registered No.

1. NAME OF DECEASED (Type or Print): William W. Perry

2. DATE OF DEATH: JAN 29 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Texas
D. STREET ADDRESS (If rural, give location): ~~Texas~~.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 year: Months / Days	If Under 24 Hours: Hours / Min.
male	White	married	1-27-70	~~79~~ 77	— / 7	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Samuel Perry
14. MOTHER'S MAIDEN NAME: Emmaline Harfelt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of prostate	? 1-5 yrs
DUE TO (B)	Post-op. septicemia staphylococcus aureus;	3 wks
DUE TO (C)	Terminal Pneumonia	3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7 Jan. 49	Carcinoma of prostate (T.U.R.)	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-27-48 *to* 1-29-49, *that I last saw the deceased alive on* 1-29-49, *and that death occurred at* 3:05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Willard C. Goodwin M. D.	JOHNS HOPKINS HOSPITAL	29 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-1-49	Jessop's Neck	Sparks, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Winfield S. Williams, M.D.	J. M. Brooks	Sparks, Md

VS 150

5 12

Correct age is especially important. Physician: please write the

G71037 ✓ 170 G71037

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): INEZ VIRGINIA KRIEDER

2. DATE OF DEATH: Jan. 27 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5924 Sefton Avenue
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5924 Sefton Avenue 2-7-44

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Widow	Nov. 21, 1876	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	USA

13. FATHER'S NAME: WILLIAM KING

14. MOTHER'S MAIDEN NAME: MARY A. STINCHCOMB

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	none	Mr. Wm. W. Phoebus	6423 Glenn Oak Ave. -14

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atherosclerotic heart disease — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma left breast & widespread metastasis — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Feb. - 1948	Carcinoma left breast & metastasis	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov. , 1948 *to* Jan. , 1949 *that I last saw the deceased alive on* Jan. 26 , 1949 *and that death occurred at* 8:40 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	4218 Hooper Rd.	1/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 29, 49	Baltimore Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Hunting for Williams, Jr.	HENRY SANDER & SONS, INC.	BALTIMORE, MARYLAND

VS 150

50

Exact age is especially important. Physician: please write the same

G71038

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 442

G71038

Registered No.

1. NAME OF DECEASED (Type or Print) ELIZABETH REYNOLDS. 2. DATE OF DEATH 1-27-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1315 Presstman St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 73 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-07
D. STREET ADDRESS (If rural, give location) 1315 Presstman St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months Days	If under 24 hours: Hours Min.
Female	Col.	W.	12-15-1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Virginia	

13. FATHER'S NAME John Carter

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no.			Pauline Trant	1315 Presstman St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio-Vascular-renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-10-1945 *to* 1-27-1949 *that I last saw the deceased alive on* 1-27-1949 *and that death occurred at* 1:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George Page M. D.	1516 N. Mount St	1-29-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Jan. 31, 1949	Sellers Fam.	Sellers, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Huntington Williams, M.D.	Geo. A. Nelson	1303 Presstman St

VS 150

1316

Correct age is especially important. Physician please

G71039
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

172 G71039
Registered No.

1. NAME OF DECEASED (Type or Print): Lena Redenaugh
2. DATE OF DEATH: Jan 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore - Md.
D. STREET ADDRESS (If rural, give location): 1133 N Caroline St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Widowed	6-30-79	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Ga
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS: Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Carcinoma of fundus uteri	June 1948 to Jan 1949
DUE TO (B)	Generalized carcinomatosis	Jan 1949
DUE TO (C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
none		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 3, 1949 *to* Jan 26, 1949 *that I last saw the deceased alive on* Jan 26 1949 *and that death occurred at* 2 10 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Walt JR M. D.	JOHNS HOPKINS HOSPITAL	Jan 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-30-49	mt auburn	md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Emily [illegible] Williams, M.D.	George G. Nelson	1302 Pennsylvania Ave

VS 150

48 B

Correct age is especially important. Physician: please write the exact

G71040 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1 ✓ G71040 Registered No.

1. NAME OF DECEASED (Type or Print): WALTER PETER HOPWOOD

2. DATE OF DEATH: 1/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1110 Poplar Grove St. 16 7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Mar. 2, 1884	64 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George W. Hopwood
14. MOTHER'S MAIDEN NAME: Elizabeth Tomlingson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 217-01-3251
17. INFORMANT: Mrs. Elizabeth Hopwood ADDRESS: 1110 Poplar Grove

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary arteriosclerosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/31/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

94a

G71041 ✓ 610

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71041

1. NAME OF DECEASED (Type or Print): CHARLES R. JOHNSON, Sr.

2. DATE OF DEATH: Jan. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for the Aged of the Meth. Church
2211 W. Rogers Ave.

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 W. Rogers Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	Sept. 17, 1869	79 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles W. Johnson	Emily Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs. M. B. Fisher	2211 W. Rogers Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular Disease

DUE TO Arteriosclerosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prostatic hypertrophy

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) ?
(B) ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 21st 1949 *to* Jan 27 1949 *that I last saw the deceased alive on* Jan 26 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles L. Warner M. D.	421 Med. Arts Bldg	1/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/31/49	Greenmount Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Eustace Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93D

Correct age is especially important. Physician: please write the same

G71042 ✓ 410 G71042

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Engle, Miss Edna Marie
2. DATE OF DEATH: 1-27-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Church Home + Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hospital
c. Length of stay in Baltimore: 28 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-09
D. STREET ADDRESS (If rural, give location): 4315 Marble Hall Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
White	Femal	Single	3-21-1892	56 yrs.	~~10~~ 6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher	Education	Sheffield Pennsylavania	U.S.A.

13. FATHER'S NAME: Dr. Oliver C. Engle
14. MOTHER'S MAIDEN NAME: Rose Lee Shannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			The deceased	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Aortic + Mitral Stenosis	44 yrs
DUE TO		
(B)	Rheumatic Fever	44 yrs
DUE TO		
(C)	[redacted]	

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
1/27/49	Cholecystitis	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-24 19~~44~~49 *to* 1-27 19~~44~~49 *that I last saw the deceased alive on* 1-27 19~~44~~49 *and that death occurred at* 9.05 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
F. Robert Haase, M.D.	Church Home + Hosp.	1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
Removal	1/31/49	Ewing Cem.	Ewing, N.J.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Hunting for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

92 B

Correct age is especial important. Physician, please see

G71043

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

434.1

Registered No. G71043

1. NAME OF DECEASED (Type or Print): Roland Edward Kilby

2. DATE OF DEATH: 1/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: 17 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6210 Carbore Way

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W	Single	May 15, 1931	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ——
10B. KIND OF BUSINESS OR INDUSTRY: ——
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Carlin P. Kilby
14. MOTHER'S MAIDEN NAME: Macy I. Marsh
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ——
17. INFORMANT: Mrs. Macy I. Kilby — ADDRESS: 6210 Carbore Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute congestive cardiac failure
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 29, 1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, Mgr
25. FUNERAL DIRECTOR: Burgee Funeral Home — ADDRESS: 3631 Falls Road

VS 151

93E

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

G71044

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1

Registered No. G71044

1. NAME OF DECEASED (Type or Print): James H. Lindemon

2. DATE OF DEATH: 1/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 830 Powers St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 830 Powers St. 13-16

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Feb. 17. 1884
9. AGE (In years last birthday): 64
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor
10B. KIND OF BUSINESS OR INDUSTRY: Penn., R.R.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Jefferson Lindemon
14. MOTHER'S MAIDEN NAME: Mary Finnerty
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Bertha M. Lindemon ADDRESS: 830 Powers St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Paul Ryan M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/31/49
24C. NAME OF CEMETERY OR CREMATORY: Poplar
24D. LOCATION (City, town or county) (State): Baltimore Co.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 29 1949
REGISTRAR'S SIGNATURE: Penelope Williams, M.D.
25. FUNERAL DIRECTOR: Paul E. Lehenmuth Sons ADDRESS: 1101 Eastern Ave.

VS 151

94a

G71045

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 180

G71045

Registered No.

1. NAME OF DECEASED (Type or Print) FRANK J. SMITH

2. DATE OF DEATH Jan 28 / 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 12 S. Mt Olivet Lane

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City 20-06
D. STREET ADDRESS (If rural, give location) 12. S. Mt. Olivet Lane

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 9-25-1881
9. AGE (In years last birthday) 67 If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10B. KIND OF BUSINESS OR INDUSTRY Rice Hamschin Co
11. BIRTHPLACE (State or foreign country) Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Smith
14. MOTHER'S MAIDEN NAME Ellen Rarbigh
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Mrs. J. Smith ADDRESS Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Metastatic Carcinoma	Several wks
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Carcinoma of Kidney	?
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 26 1949 *to* Jan 27 1949, *that I last saw the deceased alive on* Jan 27, 1949, *and that death occurred at* 8:05 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE Abram Goldman M. D.
23B. ADDRESS 206 S. Gilmor St.
23C. DATE SIGNED Jan 29 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Jan 31-49
24C. NAME OF CEMETERY OR CREMATORY Sinai Hebrew
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR H. B. Gilbert & Son
ADDRESS 1300 Eutaw St

VS 150

52a

collect age is especia important. Physicians, please

G71046 ✓ 450.0 G71046

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie E. Macherke

2. DATE OF DEATH: Jan. 25 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1829 W. Baltimore St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1829 W. Baltimore St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Dec. 9 1866	82	/	/

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Baltimore	U.S.A.

13. FATHER'S NAME: Eberhardt Berger

14. MOTHER'S MAIDEN NAME: Marie Fuchs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	None	Mrs. Arthur W. Schwartz	1829 W. Baltimore St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO

ANTECEDENT CAUSES

(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Sept 11, 1948, *to* Jan 25, 1949, *that I last saw the deceased alive on* Jan 25, 1949, *and that death occurred at* 830 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Carl P. Rozelius M. D.	1326 W Lombard St	Jan 27 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 28/49	Woodlawn Cem.	Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Hunting for Williams, M.D.	H. F. Blubert & Son	1300 Eutaw St

VS 150

97

Correct age is especially important. Physician, please write plainly.

G71047 ✓ 491 G71047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 48-22876 Registered No.

1. NAME OF DECEASED (Type or Print): Mary Louise Renehan
2. DATE OF DEATH: 1/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore City.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Yrs. — Mos. 3 Days 28

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3095 S. Augusta Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Single	10-19-1948	—	3	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
—	—	Md.	U.S.A.

13. FATHER'S NAME: Albert J. Renehan
14. MOTHER'S MAIDEN NAME: Margaret Manning (MANNING)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	—	Margaret Renehan	3095 Augusta Ave.

MEDICAL CERTIFICATION

(Effect age is especially important. Physician: please write plainly.)

16. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bilateral atelectasis with associated	3-5 days
	DUE TO Bronchopneumonia	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
None	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9 A.M. 1/25, 1949, *to* 9:55 P.M. 1/28, 1949, *that I last saw the deceased alive on* 1/25, 1949, *and that death occurred at* 9:55 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert J. Seneker M.D.	St. Agnes Hospital	1/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 31-49	New Cathedral	Baltimore - Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 29 1949	Gwendolyn Williams, M.D.	P. J. Kenkel & Son	1300 Eutaw St.

VS 150

107

G71048 ✓ 443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71048

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Brickos

2. DATE OF DEATH Jan. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1519 Lemmon LEMMON st

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 1519 Lemmon St 19 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Col.		6-1-1872	76 77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.

13. FATHER'S NAME Joseph Westley.

14. MOTHER'S MAIDEN NAME Unmore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mary Spencer	912 Boyd St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertrophic Arthritis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/29 19 48 *to* 1/25 19 49 *that I last saw the deceased alive on* 1/25 19 49 *and that death occurred at* 8 p. m. *from the causes and on the date stated above.*

23A. SIGNATURE Ralph W. Redlich Jr M. D. | 23B. ADDRESS 426 N. Gilmor St | 23C. DATE SIGNED 1/26 19 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 28 49	Russell & Calv.	Arundle Co Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 29 1949

REGISTRAR'S SIGNATURE Thurlington Williams, M.D.

25. FUNERAL DIRECTOR Elroy O Wilson ADDRESS 1000 Brantley ave 93c

VS 150

Correct age is especially important. Typewriter preferred.

37 1049 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

229

37 1049 Registered No.

1. NAME OF DECEASED (Type or Print) Emma Marshall Johnson Stewart

2. DATE OF DEATH 1.26.1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 842 Vine St. 18-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	colored	married	March 1904	44	— / —	— / —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Joshua Marshall

14. MOTHER'S MAIDEN NAME Catherine Matthews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT George Marshall ADDRESS 124 N. Schroeder

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) cerebral hemorrhage 12.16.48	about 6 wks
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Hypertensive Cardio vascular Disease	not known
	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) large degenerating pedunculated lipoma left axilla	not known

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 12.17. 1948 *to* 1.26 1949, *that I last saw the deceased alive on* 1.26 1949 *and that death occurred at* 9½ p m., *from the causes and on the date stated above.*

23A. SIGNATURE James M. Pair M. D.

23B. ADDRESS 400 N. Carrollton ave

23C. DATE SIGNED 1.27.49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Jan 29 1949

24C. NAME OF CEMETERY OR CREMATORY Mt Auburn

24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 29 1949

REGISTRAR'S SIGNATURE Kenneth Williams, M.D.

25. FUNERAL DIRECTOR Mrs Katie R. Williams ADDRESS 322 N Schroeder St

VS 150

939

G71050
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1

Registered No. G71050

1. NAME OF DECEASED (Type or Print): Katherine Jones

2. DATE OF DEATH: Jan. 28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1000 Caton Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jenkins Memorial Hospital
c. Length of stay in Baltimore: 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2-5-41

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH:
9. AGE (In years last birthday): 88 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Leonardtown Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Francis V Greenwell
14 MOTHER'S MAIDEN NAME: Mary L.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Jenkins Memorial Hospital Records ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio - Resp. Failure
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Coronary Occlusion
DUE TO
(C) Arteriosclerotic C-V Dis.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1948 to January 28, 1949, that I last saw the deceased alive on [illegible] 19[illegible] and that death occurred at 9.05 A. m., from the causes and on the date stated above.

23A. SIGNATURE: Charles E. Carr M. D.
23B ADDRESS: St. Agnes Hosp
23C DATE SIGNED: 1/29/49

24A BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/31/49
24C. NAME OF CEMETERY or CREMATORY: New Cathedral
24D LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: H. W. Weaks and Son ADDRESS: 805 W. Calvert

VS 150

correct age is especially important. Physicians, please write plainly.

937

G71051 ✓ X G71051

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 420.1 191

Registered No.

1. NAME OF DECEASED (Type or Print): JAMES A. DALTON

2. DATE OF DEATH: JAN. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL

c. Length of stay in Baltimore: 16 (Years / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WHITEHALL Rural
D. STREET ADDRESS (If rural, give location): 3 mi N. of White Hall.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	MARCH 14, 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER	FARM	MARYLAND	U.S.A.

13. FATHER'S NAME: JAMES A. DALTON

14. MOTHER'S MAIDEN NAME: HANNAH HERSEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		FRANCES DALTON	WHITEHALL, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CORONARY OCCLUSION	36 HRS.
DUE TO (B)	ARTERIOSCLEROTIC CV. DISEASE	2 YRS.+
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		6 MO.+
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INVASIVE CARCINOMA OF BLADDER	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/19/49	INVASIVE CARCINOMA OF BLADDER	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/13, 1949, *to* 1/29, 1949, *that I last saw the deceased alive on* 1/29, 1949, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul S. Ifrold M.D.	Md. Gen. Hospital	1/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Febr. 1/1949	West Liberty	White Hall, Md. R.D.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 30 1949	Huntington Williams, M.D.	Jacob Harkenstein	New Freedom, Pa.

52 B

Correct age is especially important. Physician please write plainly.

422.1 G71052

G71052

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): (MARIAN) MARION F(GOSLEE) GOSLEE

2. DATE OF DEATH: January 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 303 E. North Avenue 12-05

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept.1, 1877
9. AGE (In years last birthday) If Under 1 Year Months Days If Under 24 Hours Hours Min.: 71 (djm)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Clerk
10B. KIND OF BUSINESS OR INDUSTRY: U.S.F & G.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Alex Goslee
14. MOTHER'S MAIDEN NAME: Elizabeth Robinson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Lula R. Goslee, 303 E. North Avenue ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic CV disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: C. J. Lalumandier M.D.
23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): removal
24B. DATE: 1/30/49
24C. NAME OF CEMETERY OR CREMATORY: East New Market Cemetery
24D. LOCATION (City, town, or county) (State): East New Market, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 30 1949
REGISTRAR'S SIGNATURE: Constance Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Wm. Cook, Inc., 1217 St. Paul Street

VS 151

6

93D

Collect age is especially important. Physicians please write the cause of death

BIRTH NO. G71053

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71053

1. NAME OF DECEASED (Type or Print): JULIA MELISSA ADLER

2. DATE OF DEATH: Jan.29,1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1717 Aisquith St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1717 Aisquith St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	White	Widow	Nov.18,1862	86	2	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore,Md	

13. FATHER'S NAME: Eben Staples

14. MOTHER'S MAIDEN NAME: Julia Dashields

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		None	Miss Hattie B. Adler,	1817 Aisquith St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio Sclerotic Heart D. — Interval between onset and death: 3 years

DUE TO

(B)

DUE TO

(C) Nephrosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 21, 1948, *to* Jan 28, 1949 *that I last saw the deceased alive on* 1/28, 1949, *and that death occurred at* 1 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. O. Smith M. D.	1223 E. North Ave	1/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/31/49	Baltimore	Baltimore,Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 30 1949	Huntington Williams, M.D.	William Cook, Inc.,	1217 St.Paul St.

HS 150

JAN 30 1949

1312

Subject age is especial importance, if physician, please see

✓ 422.1

G71054 BALTIMORE CITY HEALTH DEPARTMENT G71054

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Philip Corso

2. DATE OF DEATH Jan. 28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home for the aged Poor Sillo Asylum of the Poor

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1200 Valley St 10 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	M.	Mch 24-1875	73-		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Produce dealer			U.S.

13. FATHER'S NAME Sonio Carso

14. MOTHER'S MAIDEN NAME Mary Someone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Sister Ignatius	1200 Valley St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio - Sclerosis — 10 yr

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 10- 1949, *to* Jan 28 1949, *that I last saw the deceased alive on* Jan 27- 1949, *and that death occurred at* 9 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E Gill Hall M. D.	1631 E North Ave	Jan 29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 31, 1949	Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 30 1949 VS 150

REGISTRAR'S SIGNATURE: Clarence Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Rita Wiedefeld 900 E. Biddle St

937

Correct age is especially important. Typewriter preferred.

Dr. Gordy

✓ 422.2

BIRTH NO. G71055

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71055

1. NAME OF DECEASED (Type or Print): Anna Valentine

2. DATE OF DEATH: Jan. 28. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pineridge Nursing Home

c. Length of stay in Baltimore: Yrs. 9 Mos. Days 06

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2011 East 31st Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widowed	Mar. 7, 1864	84				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ? Oelman

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Valentine, 4308 Arabia Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho-Pneumonia (Hypostatic) — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

(B) Chronic Myocarditis — 10 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	no	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 1st, 1939, *to* Jan 28th, 1949, *that I last saw the deceased alive on* Jan 24, 1949, *and that death occurred at* 4:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. L. Gordy, M. D.	5106 Harford Road	1-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	1-31-49	Parkwood Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 30 1949	[illegible]	Leonard J. Ruck, 5305 Harford Road.

VS 150

937

Correct age is especially important. If person was [illegible]

Dr. Harding 2-4
3805 Belair Road

✓ 422.2G71056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71056

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM RITTERSHOFER

2. DATE OF DEATH: Jan. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2710 Kennedy Avenue

c. Length of stay in Baltimore: Yrs. 9 Mos. 07 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2710 Kennedy Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	Dec. 6, 1887	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bottling Dept.	Arrow Brewery	Baltimore, Maryland	

13. FATHER'S NAME: Phillip Rittershofer

14. MOTHER'S MAIDEN NAME: Lena Bochner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Della Rittershofer, ADDRESS 2710 Kennedy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 36 hours
DUE TO
(B) Ch. Myocarditis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 15, 1948, *to* Jan 28, 1949, *that I last saw the deceased alive on* Jan 28, 1949, *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H Harding M. D.	3805 Belair Rd	1/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-31-49	Oaklawn Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 30 1949	Huntington Williams M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

937

Cause of death is especially important. Physician, please write plainly.

G71057

BALTIMORE CITY HEALTH DEPARTMENT 231 G71057

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Frances LoHN.

2. DATE OF DEATH 1-29-49 3:30 A.M.

3. PLACE OF DEATH: A. Baltimore City, Maryland St. Agnes Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caton + Wilkens Ave.

c. Length of stay in Baltimore 27 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 346 Marydell Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md

D. STREET ADDRESS (If rural, give location) 346 Maydell Road. 31

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W	M.	May 3, 1911	37	8 / 26	— / —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Maryland	U.S.A.

13. FATHER'S NAME Milton Corbin

14. MOTHER'S MAIDEN NAME Catherine Grimes.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Norman H. Lohn	346 Maydell Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral bronchopneumonia severe — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Secondary anemia - from neoplasm of antrum

DUE TO

(over)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-14 1949 *to* 1-29 1949, *that I last saw the deceased alive on* 1-29 1949, *and that death occurred at* 3:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sidney Johnson Veatch M.D.	St. Agnes Hospital	1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	February 1, 1949	Loudon Park	Baltimore, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Huntington Williams, M.D.	George L. Schwab	2101 Frederick Ave.

VS 150

57E

Correct age is especially important. Physician: please write plainly.

71058 Bl ✓022 G710:58

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Smith

2. DATE OF DEATH JAN 29 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2218 N. Howard St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 30 Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored	Married	10-12-96	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		S. C.	

13. FATHER'S NAME John Smith

14. MOTHER'S MAIDEN NAME Millie Brad ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Rupture of aneurysm from just above aortic ring into left ventricle	? 1 w.
DUE TO	(B) Syphilitic aortitis	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(C) Cardiovascular syphilis	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Bronchopneumonia - 5 lobes - due to pneumonia	2 w

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	5 LOBES	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-27- 1949 *to* 1-29- 1949 *that I last saw the deceased alive on* 1-29 1949 *and that death occurred at* 935 *p*m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D Jackson M. D.	JOHNS HOPKINS HOSPITAL	1/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-2-49	Roslyn Knoll	Sumter S. C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Funeral for Williams, M.D.	Samuel W. Sullivan Jr.	Balto. Md.

VS 150

305

correct age is especially important. Physician: please write plainly

71059 ✓ 162 G71059

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

1. NAME OF DECEASED (Type or Print): JAMES COLUMBUS BROOKS

2. DATE OF DEATH: Jan. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore: ? Yrs. ? Mos. ? Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1419 Argyle Ave. 14-0 2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	Col	Sep.	11/15/04	44	2	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Porter	?	Newport News, Va.	USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Hattie Pearl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 2	?	Records- USMarine Hospital	Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Squamous cell Carcinoma of ~~left~~ right lung with metastasis, widespread	Unknown
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

(over)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Dec. 28, 1948, *to* Jan. 26, 19 49 *that I last saw the deceased alive on* Jan. 26 19 49, *and that death occurred at* 7:20P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Sr. Surgeon (Clinical) Director M. D.	US Marine Hospital, Balto, Md.	1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/1/49	Balto. Nat.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Acting for Williams, M.D.	W. H. Halstead - 918 Druid Hill Avenue	

VS 150

Correct age is especially important. Physician, please answer

✓422.1 G71060

G71060

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71060

1. NAME OF DECEASED (Type or Print): IRENE DUNCAN

2. DATE OF DEATH: JAN. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — N21 LESLIE ST
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
c. Length of stay in Baltimore: 25 Yrs. (Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE / B COUNTY: N21 LESLIE ST BALTO MD
C. CITY OR TOWN (If outside corporate limits, write BOROUGH, and give township): 15-01
D STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
FEMALE	NEGRO	WIDOW	JAN 5 1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	—	KENTUCKY	U.S.

13. FATHER'S NAME: AVION SCOTT

14. MOTHER'S MAIDEN NAME: MARGARET — ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
NO		MILDRED TAYLOR

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL DEGENERATION — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) SENILITY - ARTERIO-SCLEROSIS

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 1, 1948, to Jan 27, 1949 *that I last saw the deceased alive on* 1-27-49 *and that death occurred at* 12:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1723 Druid Hill Ave	1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-31-49	mt auburn	md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Huntington for Williams, M.D.	George G. Kelson	1303 Brentwood St

VS 150

93D

G71061

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

447 G71061

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLARA THOMAS.

2. DATE OF DEATH 1/26/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 326 N. Mount St.

C. Length of stay in Baltimore 2 Yrs. 6 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore B. COUNTY Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 326 N. Mount St. 19-01
D. STREET ADDRESS (If rural, give location) 1/10/1885

5. SEX Female
6. COLOR OR RACE Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH
9. AGE (In years) Last birthday 63, 3
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic,
10B. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (State or foreign country) Balto Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Not Known
14. MOTHER'S MAIDEN NAME Manley Lowell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. No
17. INFORMANT Gertrude Smith ADDRESS 326 N. Mount

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial Nephritis DUE TO Hypertension — INTERVAL BETWEEN ONSET AND DEATH 2 mo 2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/4/48 *to* 1/26/49, *that I last saw the deceased on* Jan 26th 1949, *and that death occurred at* 2 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE J. H. Burns M. D.
23B. ADDRESS 522 N Arlington
23C. DATE SIGNED 1/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1-31-49
24C. NAME OF CEMETERY OR CREMATORY Mt Auburn
24D. LOCATION (City, Township or County) (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 31 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR George G. Nelson ADDRESS 1303 Brentwood

VS 150

1312

G71062 ✓ 443 G71062

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Jeanette Webb GEMMILL

2. DATE OF DEATH: 29 January 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3333 Calvert

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.

c. Length of stay in Baltimore: 5-9 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. COUNTY: ~~Baltimore~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3333 No. Charles Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Divorced	9-13-89	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk - Stated Md.
10B. KIND OF BUSINESS OR INDUSTRY: Social Security
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Webb
14. MOTHER'S MAIDEN NAME: Sarah Evans
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: NONE
17. INFORMANT: Miss Dorothy Webb ADDRESS: 1150 Fred Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) hypertensive cardiovascular disease — 5 years
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-22 1949 *to* 1-29 1949, *that I last saw the deceased alive on* 1-29 1949, *and that death occurred at* 9:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE: W. F. Coy 3d M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-31-49
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Stewart Home Co. ADDRESS: Balto 6

VS 150

93D

Correct age is especially important. Typewriter preferred.

G7.1063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

203 G7.1063

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Sattie Weiner

2. DATE OF DEATH: 1/30/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 38 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3417 Garrison Blvd.

5. SEX: F.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1890
9. AGE (In years last birthday): 58 | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: David Nudler
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Aaron Weiner ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Multiple myeloma
DUE TO
(B) (proven by bone marrow studies).
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/22/49 19__, *to* 1/30/49 19__, *that I last saw the deceased alive on* 1/30/49 19__, *and that death occurred at* 7.50 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry V. Chase M.D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-31-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Rosedale
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Levinson Bros, ADDRESS: 1124 W North Ave

VS 150

55E

collect ago is especially important. Typewriter

71064 ✓ 422.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 71064

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis Birenbaum

2. DATE OF DEATH: January 30/ 49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 2205 Bryant Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 30yrs (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 2205 Bryant Ave / 3-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
Male	White	Married	1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Paper Hanger		Russia	

13. FATHER'S NAME: Morris Birenbaum

14. MOTHER'S MAIDEN NAME: Gittel ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs Ida Birenbaum	2205 Bryant Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Pulmonary Hemorrhage

DUE TO

(B) Chronic Lung Abscess

DUE TO

(C) Arteriosclerotic CVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 1947 *to* Jan 30, 1949, *that I last saw the deceased alive on* Jan 30, 1949, *and that death occurred at* 7.45 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard Applefeldman M. D.	2511 Reisterstown Rd	1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-31-49	Hebrew Rosedale Cem	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Huntington Williams, M.D.	Levinson Bros.	1124 N North Avenue

VS 150

93D

Cancer age is especially important

G71065 ✓ 420.1 G71065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Charles Wabatka. (Wabatkas) 2. DATE OF DEATH JAN 28-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1413 Hobbins St Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1413 Hobbins ST. 1903

c. Length of stay in Baltimore 40 yr Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married		63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Lith.	?

13. FATHER'S NAME Charles Walatka

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	218-01-0100	Mary Wabatka	1413 Hollins St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute coronary thrombosis — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 30 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) coronary arteriosclerosis — DUE TO — 2 yrs

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(C)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 17 1949 *to* Jan 28, 1949, *that I last saw the deceased alive on* Jan 28, 1949, *and that death occurred at* 12:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Milton B Kusch MD M. D.	2320 Eutaw Pl	Jan 29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	JAN 31-1949	Holy Redeemer	Belair Rd Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	[illegible] for Williams MD	Joseph Kasmakas Jr	602 Wash. Blvd

VS 150

94a

correct age is important for statistical purposes

G71066 762.0 G71066

BIRTH NO. BC. 49-01307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Stevenson (487344)

2. DATE OF DEATH: January 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1517 Linden Avenue 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	single	January 25, 1949			8 26

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baby		Maryland	

13. FATHER'S NAME: Edward Stevenson

14. MOTHER'S MAIDEN NAME: Theresa Hamrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Theresa Stevenson	1517 Linden Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intra-Uterine anoxia

DUE TO

(B) Ruptured marginal sinus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 25, 1948 *to* Jan. 26, 1949 *that I last saw the deceased alive on* Jan. 26, 1949, *and that death occurred at* 3:38 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Glen G. Rice M. D.	601 North Broadway	1-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
		Holy Redeemer	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Huntington Williams, M.D.		

VS 150

104 B

correct age is objective, important

71067 ✓ 420.1 G71067

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James H. Reed

2. DATE OF DEATH: 1/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
c. Length of stay in Baltimore: 25 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1025 N. Durham St. 7-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	C	Married	Apr. 24, 1896	52 53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Va.	

13. FATHER'S NAME: Eliz Reed

14. MOTHER'S MAIDEN NAME: Ida Reed

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes World War I	216-09-5432	Roy Reed	1025 N. Durham St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease — DUE TO

ANTECEDENT CAUSES

(B) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George S. Merrill M.D.	☒	1/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/31/49	Mt. Calvary	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Huntington Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave

VS 151

94a

correct age is especially important. Physicians, please

G71068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 G71068

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Brill

2. DATE OF DEATH: Jan 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 833 N. Patterson Park Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
B. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 833 N. Patterson Park Ave. 7-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Mar. 22, 1877	71	10	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home		Baltimore, Md.	

13. FATHER'S NAME: Wil iam Brill

14. MOTHER'S MAIDEN NAME: Catherine A. Lauf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Wil.iam Brill 833 N. Patterson Park Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypertension Heart Disease	1 mo.
DUE TO (B)	Pulmonary Edema	1 dy
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 26, 1949 *to* Jan 28, 1949 *that I last saw the deceased alive on* Jan 28, 1949 *and that death occurred at* 11 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred Rouse M. D.	100 N Patterson Park Ave	1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 31, 1949	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 31 1949	Cynthia for Williams, M.D.	Ulrich Funeral home 2008 Orleans St.

VS 150

93D

G71069 ✓442 G71069

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Henrietta Burley

2. DATE OF DEATH: 1-28-49

3. PLACE OF DEATH: a. Baltimore City, Maryland 1313 Upton St

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 30 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. ~~CITY~~ OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1313 Upton St 17-03

5. SEX: F
6. COLOR OR RACE: col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1882
9. AGE (In years last birthday): 66 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Harmans a.a. Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: alfred Harris
14. MOTHER'S MAIDEN NAME: Sarah Queen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Wm J Bailey (Son) ADDRESS: 1313 Upton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) hypertensive cardio-renal disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/26, 1949 *to* 1/28, 1949, *that I last saw the deceased alive on* 1/27, 1949 *and that death occurred at* 5.45 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1500 E Madison St
23C. DATE SIGNED: 1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 1-1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): City Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Contingent for Williams M.D.
25. FUNERAL DIRECTOR: Wm Brooks ADDRESS: 1463 N. Carey St.

VS 150

131a

Medical Exam Case

G71070 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH E 903.0 N 820

G71070 Registered No.

1. NAME OF DECEASED (Type or Print) Catherine Duerling (Mrs.)

2. DATE OF DEATH Jan 30 '49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 5615 Magnolia Ave 7-7-19

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 1-5-68 | 9. AGE (In years last birthday) 81 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	FRACTURE, Femur, Neck, Bilateral	7 Days
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	1. Arteriosclerosis 2. Bronchopneumonia	1. 30 years 2. 2 Days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

CERTIFICATION APPROVED BY
Cor: Wm. G. Hellrich M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION —
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5615 Magnolia ave, Baltimore
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 24 January 1949 p m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Fell walking at home

22. *I hereby certify that I attended the deceased from* Jan 25 *to* Jan 30, 1949 *that I last saw the deceased alive on* Jan. 30, 1949 *and that death occurred at* 4 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE John William Hillman M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED Jan 30, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Inter
24B. DATE 2/2/49
24C. NAME OF CEMETERY OR CREMATORY Woodlawn
24D. LOCATION (City, town, or county) (State) Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 31 1949
REGISTRAR'S SIGNATURE Certificate for Williams, M.D.
25. FUNERAL DIRECTOR Wilson & Doe 1210 Eutaw St ADDRESS

VS 150 To be approved by Medical Examiner 186

G71071 ✓334 G71071

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Rosa English

2. DATE OF DEATH: Jan 29. 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 123 W. Henrietta

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 123 W. Henrietta St

C. Length of stay in Baltimore: 12 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: 123 W. Henrietta St.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. md
D. STREET ADDRESS (If rural, give location): 123 W. Henrietta St. 3-01

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 1899
9. AGE (In years last birthday): 49 yrs (If under 1 year: Months — / Days — / If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Littleton - N.C.
12. CITIZEN OF WHAT COUNTRY? —
13. FATHER'S NAME: Kash Alston
14. MOTHER'S MAIDEN NAME: Roda —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: Harry English. ADDRESS: 123 W. Henrietta

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Neighborly friendly Kind by Aunt Broadway

INTERVAL BETWEEN ONSET AND DEATH: 2 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/24/49, 19__, to 1/29/49, 19__, that I last saw the deceased alive on 1/24/49, and that death occurred at ____ m., from the causes and on the date stated above.

23A. SIGNATURE: W. S. Ramsdale M. D.
23B. ADDRESS: 526 N. Carey St
23C. DATE SIGNED: 1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 3-49
24C. NAME OF CEMETERY OR CREMATORY: Littleton. N.C.
24D. LOCATION (City, town, or county) (State): N.C.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: James A Hayes
ADDRESS: 142 W. Kelly

VS 150

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G71072 ✓331 G71072

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): REBECCA KATZ
2. DATE OF DEATH: 1-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3915 Park Heights Ave
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-17
D. STREET ADDRESS (If rural, give location): 3915 Park Heights Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married	1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Simon Rothstein
14. MOTHER'S MAIDEN NAME: Fannie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Reuben Katz ADDRESS: 3915 Park Hgts Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	10 days
DUE TO	arteriosclerosis	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	diabetes mellitus	15 yrs
DUE TO	Hypertension	
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1935 *to* Jan 30, 1949, *that I last saw the deceased alive on* Jan 30, 1949, *and that death occurred at* 6-7 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Meem B Kirby M. D.
23B. ADDRESS: 2320 Eutaw Pl
23C. DATE SIGNED: 1/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-31-49
24C. NAME OF CEMETERY OR CREMATORY: Shaarei Zion
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

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G71073 ✓ 334 G71073

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ABRAHAM I LAVY
2. DATE OF DEATH: 1-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Leo'ndale Home
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Leo'ndale Home
C. Length of stay in Baltimore: 41 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 4034 Boarman Ave 15-10

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~ MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W		12-23-1905	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
accountant		Poland	amer.

13. FATHER'S NAME: Nathan Lavy
14. MOTHER'S MAIDEN NAME: Dora Sleskin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Dr. Lavy	1844 W. North Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral arteriosclerosis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7-13, 1948, to 1-30, 1949, *that I last saw the deceased alive on* 1-30, 1949 *and that death occurred at* 10 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Nagel M. D.	Leo'ndale Home	1-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-31-49	Adas Israel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

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71074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 978.2

Registered No. 71074

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Henrietta E WICKES N-1971 | 2. DATE OF DEATH JAN. 29 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPT.
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.
D. STREET ADDRESS (If rural, give location) 701 CATHEDRAL ST. 11-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	SINGLE	NOV. 22, 1874	74	2	7

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MO.	U.S.A.

13. FATHER'S NAME PERE L. WICKES

14. MOTHER'S MAIDEN NAME HENRIETTA WELSH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT W.F. WICKES ADDRESS 12 BISHOP RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Barbiturate poisoning (Phenobarbital)	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C) History of mental depression	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 701 Cathedral St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 1 26 49 ? m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Ingestion of barbiturate tablets

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 1/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE JAN. 31, 1949

24C. NAME OF CEMETERY OR CREMATORY GREEN MOUNT

24D. LOCATION (City, town, or county) (State) BALTO., MD.

DATE RECEIVED BY LOCAL REGISTRAR JAN 31 1949

REGISTRAR'S SIGNATURE Hattie Lee Williams M.D.

25. FUNERAL DIRECTOR H.W. JENKINS & SONS ADDRESS 4907 YORK RD.

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correct age is especially important. Physicians, please write plainly.

71075 420.1 Registered No. 71075

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3913 Carlisle Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 15 09
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Carlisle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Paul Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-8163

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~

6 (b) Name of husband ~~or wife~~ Louise Jenkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4. 1881

8. AGE: Years 67 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Greenfield - Mass
(Town, county, and state)

10. Usual Occupation Chemist

11. Industry or business H. F. Gilpin Co

FATHER
12. Name Morris Jenkins
13. Birthplace Mass

MOTHER
14. Maiden Name ~~Katie Dunklee~~
15. Birthplace Greenfield Mass.

16 (a) Informant Louise F. Jenkins
(b) Address 3913 Carlisle Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/31/49 (month) (day) (year)
(c) Cemetery ~~Interment~~ New Green River
Location Greenfield, Mass

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. Md.

19 JAN 31 1949 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1949 at 6.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1948 to Jan 30 1949 and that I last saw ~~him~~ alive on Jan 30 1949.

Immediate cause of death Coronary Thrombosis

Duration 1 1/2 yrs

Due to Cardio-vascular disease
Due to hypertension

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles L. Warner M. D.
Address 421 Med. Arts Date signed

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Building 93 Jan 30.49

G71076 ✓ 331 G71076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELLA S. SCHULZ

2. DATE OF DEATH: Jan. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2601 Roslyn Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kenesaw Rest Home
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): baltimore
D. STREET ADDRESS (If rural, give location): 2601 Roslyn Ave. 15-38

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec. 21, 1865
9. AGE (In years last birthday): 83
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles L. Schulz
14. MOTHER'S MAIDEN NAME: Sophia L. Schaer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mr. R. D. Wilson ADDRESS: 2601 Roslyn Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Haemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks.
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Arterio Sclerosis — some years.
DUE TO
(C) old age.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 1 1948 *to* Jan 30, 1949, *that I last saw the deceased alive on* 1-29-, 1949, *and that death occurred at* ___ p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert C. Blake M. D.
23B. ADDRESS: Med. arts Bldg.
23C. DATE SIGNED: 1-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/2/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR ADDRESS: Wm. J. TICKNER & SONS INC. BALTO. MD.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 G71077 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CORA B. GIBSON

2. DATE OF DEATH: Jan. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 445 Whitridge Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 47 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 445 Whitridge Ave. 12-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Separated	Dec. 9, 1868	80 Yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home	-	Pa.	USA

13. FATHER'S NAME: Benjamin La Mottee

14. MOTHER'S MAIDEN NAME: Alice Hetrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mrs. Walter Kuhn 4625 Montgomery Ave ADDRESS: Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	2 wks.
DUE TO (B)	Broncho-pneumonia	10 days.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	-	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Not		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 17th, 1949, *to* Jan. 29, 1949, *that I last saw the deceased alive on* Jan. 29, 1949, *and that death occurred at* 8 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Earl L. Chambers, M. D.	4108 Liberty Hts Ave.	1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	2/1/49	New Freedom	New Freedom Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 31 1949	Huntington Williams, M.D.	WM. J. TICHNER & SON INC. BALTO. MD.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): John Lawrence Malone

2. DATE OF DEATH: January 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR [illegible] (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1609 N. Chapel 8-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W.	Married	July 12, 1902	46	6	16		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None (Ship Yard Work) Painter
10B. KIND OF BUSINESS OR INDUSTRY: Paint Sprayer
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John L.Malone
14. MOTHER'S MAIDEN NAME: Elizabeth Cremens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: 219-07-0560
17. INFORMANT: Lillian A.Malone,1609 N.Chapel — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cirrhosis of liver	
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Malnutrition + avitaminosis	

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 10, 1949 *to* Jan. 28, 1949 *that I last saw the deceased alive on* Jan. 28, 1949 *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Philip A Peter M.D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: Jan. 28, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-I-49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Edmondson Avenue,Balto;Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Curtis for Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: George J.Ruth,Inc.,1735 Harford Avenue

VS 150

1248

G71079

BALTIMORE CITY HEALTH DEPARTMENT 422.1 G71079

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary C. Holden

2. DATE OF DEATH: 1/28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2512 Harford Rd.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: M.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2512 Harford Rd. 9-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
F	W	Widowed	July 5th.,1864	84	6	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	At Home	Baltimore,Maryland	

13. FATHER'S NAME: Thomas Doory

14. MOTHER'S MAIDEN NAME: Annie Connolly ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	None	Mrs.Catherine B.Prodoehl,Balto:Md.	2512 Harford Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Lobar Pneumonia	
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Generalized Arteriosclerotic Cardio vascular Disease	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	M.D.	23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
[signature]			1/29.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-I-49	New Cathedral	Edmondson Ave.Balto:Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Huntington Williams, M.D.	George J.Ruth,Inc.,	1735 Harford Avenue

VS 151

108

G71080 ✓153 G71080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Howard Chester Callender — HOWARD C. CALLENDER

2. DATE OF DEATH: 1-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 3042 E. Monument St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	5-3-81	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	Kress Dairy	Md	USA

13. FATHER'S NAME: Luther W. Callender — Luther Callender
14. MOTHER'S MAIDEN NAME: Laura Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	217-22-2632	Carrie Callender	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 4 mos +

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-10-49	Ca of colon	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-29-, 1949, *to* 1-29-, 1949, *that I last saw the deceased alive on* 1-29-, 1949, *and that death occurred at* 11:20 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allyn F. Judd M. D.	Mercy Hospital	1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-3-49	Greenmount	Greenmount Ave. Balto: Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Huntington Williams, M.D.	Frederick D. Miller Inc.	3019 E. Monument Street

VS 150

46E

G71081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 919.5 N861

Registered No. G71081

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LEO F. LEBON, JR.

2. DATE OF DEATH: January 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 917 Ramsay Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
male	white		August 22, 1938	10	5	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Baltimore, Md.	U.S.

13. FATHER'S NAME: Leo. F. LeBon, Sr.

14. MOTHER'S MAIDEN NAME: Elenora A. Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Mr. Leo F. Lebon	917 Ramsay St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bullet Wound of Heart
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Carrollton Ave. & Hollins Street 18/3
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 29 49 7.37 p.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Emil H. Pozen M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	2/1/49	Baltimore Cem.	E. North Ave & Rose St

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son ADDRESS: 907 Hollins St

VS 151

184

G71082 ✓ 422.1 G71082

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print)	THOMAS	PORTER	2. DATE OF DEATH January 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

C. Length of stay in Baltimore 7 yrs (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 923 McHenry Street (NW) 21-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	White	Married	March 17, 1877	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	WATCHMAN	Eastern Shore, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Porter	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	-	-	Mrs. Bessie E. Bulett	923 McHenry St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
C. P. Sulsenbe M.D.		1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/1/49	Meadowridge Mem Pk.	Dorsey Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Huntington Williams, M.D.	John J. Cowan & Son	901 Hollins St.

VS 151

93D

G71083 ✓ 154 G71083

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): George A. Ward

2. DATE OF DEATH: 1/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1811 N. Bond St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Life — Yrs. 8 Mos. 05 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto
B. COUNTY: Md
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Md
D. STREET ADDRESS (If rural, give location): 1811 N. Bond St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov 10th 1892
9. AGE (In years last birthday): 56 — 57
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Builder Decorator
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Michael Ward
14. MOTHER'S MAIDEN NAME: Ella Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-10-1479
17. INFORMANT: Mrs. Ward — ADDRESS: 1811 N. Bond St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Toxic Absorption	4 days.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Carcinoma of Rectum	2 years.
	DUE TO (C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION: June 1947. July 1948
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Rectum
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1947, *to* January 29, 1949, *that I last saw the deceased alive on* Jan. 29, 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Michael J. Dausch M.D. M. D.
23B. ADDRESS: 1 W. Chesley Ave
23C. DATE SIGNED: 1-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 2nd 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Hunting for Williams, M.D.
25. FUNERAL DIRECTOR: Leo F. Loock — ADDRESS: 1703 N. Patterson Park Ave

46D

BIRTH NO. 71084

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1960 5

Registered No. 71084

1. NAME OF DECEASED (Type or Print): Baby Boy Simpson

2. DATE OF DEATH: January 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellicott City
D. STREET ADDRESS (If rural, give location):

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Child	1-27-49			1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Raland Simpson

14. MOTHER'S MAIDEN NAME: May Belle Suets

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ventricular Hemorrhage

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-27 1949 *to* 1-28, 1949 *that I last saw the deceased alive on* 1-28, 1949, *and that death occurred at* 6 55 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Eugene O. Goldstein M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-1-49

24C. NAME OF CEMETERY OR CREMATORY: Southern Chapel

24D. LOCATION (City, town, or county) (State): Clarksville Howard Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949

REGISTRAR'S SIGNATURE: Deputy for Wilkinson, M.D.

25. FUNERAL DIRECTOR: H. Hejinbothom ADDRESS: Ellicott City Md.

VS 150

1160a

AB-125692

1085
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 521

G71085
Registered No.

1. NAME OF DECEASED (Type or Print) Sylvester Alexander

2. DATE OF DEATH Jan. 27-1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 28 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 1216 St. James Street 10-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	Single	Sept-6-1905	43				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Eugene Alexander

14. MOTHER'S MAIDEN NAME Mary Parson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Baltimore City Hospitals Records — ADDRESS 4940 Eastern Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Abscess, pulmonary, c hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO

II
(C)
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. AND — ?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 31- , 1948 *to* Jan. 27- , 1949, *that I last saw the deceased alive on* Jan. 27, 1949, *and that death occurred at* 7.55 Pm *from the causes and on the date stated above.*

23a. SIGNATURE Merrill T. Nelson M. D. — 23b. ADDRESS Baltimore City Hospitals — 23c. DATE SIGNED 1-30-49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	1/31/49		Washington Va.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949 VS 150

REGISTRAR'S SIGNATURE: Hunting for Williams, M.D.

25. FUNERAL DIRECTOR: Robt. H. Arnold — ADDRESS: 1216 E. Baltimore St.

93D

G71086 ✓ 794 G71086

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): L. David Vester
2. DATE OF DEATH: Jan. 29 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 115 W. First ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 115 W. First ave
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md
D. STREET ADDRESS (If rural, give location) 115 W. First ave 43-0

c. Length of stay in Baltimore 96 Yrs 10 Mos 6 Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widower	March 23, 1852	96	10	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cooper	Cooper	Balto Md	U.S.

13. FATHER'S NAME: L. Dave Vester
14. MOTHER'S MAIDEN NAME: Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Howard Vester	115 W. First Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility without Dementia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 22, 1948 *to* Jan 29, 1949, *that I last saw the deceased alive on* Jan 28, 1949 *and that death occurred at* 6:45 A.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James E. Peterman M. D.	1226 Hanover St.	Jan 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 1 1949	Mt Olivet	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Huntington Williams, M.D.	A. Howard Evans	1460 Charles St

VS 150

162 B

G71087 ✓ 331 G71087

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 3698

1. NAME OF DECEASED (Type or Print): Matilda Anderson

2. DATE OF DEATH: 1-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1116 Whatcoat
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1116 Whatcoat St. Baltimore Md.
C. Length of stay in Baltimore: 23 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1116 Whatcoat St. 16 or

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 1-27-1911
9. AGE (In years last birthday): 38 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: House wife
11. BIRTHPLACE (State or foreign country): Middlesex Va
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Percy Dixon
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Harry Anderson ADDRESS: 1116 Whatcoat St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebal hemorrhage	Sameday
DUE TO (B)	Hypertension	Unknown
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Acute respiratory infection	10 days
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-17- , 1949 *to* 1-27- , 1949 *that I last saw the deceased alive on* 1-27- 1949. *and that death occurred at* 6 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Frank A. Saunders M. D.
23B. ADDRESS: 1029 N. Stricker St.
23C. DATE SIGNED: 1-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 31, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Hunter G. Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R Williams ADDRESS: 322 N

VS 150

83a

G71088 581.0 ✓ G71088

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Marshall H. Anderton

2. DATE OF DEATH: Jan. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1629 E. Oliver Street 8 07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	About 50			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Unemployed	Baltimore, Maryland.	

13. FATHER'S NAME: Frank M. Anderton

14. MOTHER'S MAIDEN NAME: Rose Hopkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Unknown		Mrs. Rose E. Anderton	1629 E. Oliver

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hematemesis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Ruptured Esophageal Varices

DUE TO

(C) Cirrhosis of the Liver — 8 mo

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 27, 1949, *to* Jan 29, 1949 *that I last saw the deceased alive on* Jan 29, 1949, *and that death occurred at* 8:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph J. Bowen Jr. M.D.	Mercy Hospital	Jan 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 2, 1949	Cathedral	Balt. more, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Evelyn F. Williams, M.D.	H. H. Mears and Son	805 N. Calvert St.

VS 150

124B

BIRTH NO. 71089

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 422, 71089

1. NAME OF DECEASED (Type or Print): Albert G Vogel

2. DATE OF DEATH: 1/31/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2333 Edmondson Ave. 20 - 0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	MARRIED	MARCH 26 1879	69	10	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN	KOESTERS BAKER	BALTIMORE MD	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WEIGAND VOGEL	NOT KNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
MD	NO.		MRS MYRTELLA VOGEL	2333 EDMONDSON AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis

(B) Cardiac Insufficiency

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection - Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE [signature] M.D | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED 1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	FEB-3-1949	WOODLAWN	WOODLAWN MD.

DATE RECEIVED BY LOCAL REGISTRAR: 1-31-1949

REGISTRAR'S SIGNATURE: [signature] M.D

25. FUNERAL DIRECTOR | ADDRESS: MRS CHAS A.G. RONDE 2327 EDMONDSON AVE

VS 151

937

G71090 ✓ H 20.1

BALTIMORE CITY HEALTH DEPARTMENT G71090

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) **Rachel A. McCleary**

2. DATE OF DEATH **Jan. 27/49**

3. PLACE OF DEATH: A. **Baltimore City, Maryland** **110 N. Hilton St.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mos. Days **Life**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **110 N. Hilton St.**

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	**White**	**Widow**	**July 1,1860**	**88**	**6 25**	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		**Md.**	

13. FATHER'S NAME **Taylor**

14. MOTHER'S MAIDEN NAME **Donaldson**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			**Mrs. John A. Dietrich**	**2918 Elgin Ave.**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Coronary Occlusion** — INTERVAL BETWEEN ONSET AND DEATH: ✓

DUE TO

(B) **Arthritis Deformans** — **10 years**

DUE TO

(C) **General Arteriosclerosis** — ✓

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	✓	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	**none**	✓

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
✓ m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	✓

22. *I hereby certify that I attended the deceased from* **Nov 11**, 19**44** *to* **Jan 27**, 19**49** *that I last saw the deceased alive on* **Jan 26**, 19**49**, *and that death occurred at* **6** A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Calvin H. Richmond M.D.	**1219 Druid Park Drive**	**1/29/49**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial 1949	**Jan. 31/49**	**Loudon Pk.**	**3801 Frederick Rd. Balto. Md**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
		Harry H. Wittstadt	**4101 Edmondson Ave.**

VS 150

94a

✓ 443 G71.091

G71.091

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Samuel Hawkins

2. DATE OF DEATH Jan 28, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Md b. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md.

c. Length of stay in Baltimore ? Yrs. Mos. Days

d. STREET ADDRESS (If rural, give location) 336 Forest St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Col.	Single	Dec. 23 1892	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Wasington Dc.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William H. Hawkins

14. MOTHER'S MAIDEN NAME Martha Jane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Catharine Stevenson ADDRESS 401 Forest St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebr - vascular hemorrhage DUE TO	1 Day
ANTECEDENT CAUSES	(B) Hypertensive Cardio - vascular disease DUE TO	?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

20. AUTOPSY? YES ☐ NO ☒

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 27, 1949, *to* Jan 28, 19 49, *that I last saw the deceased alive on* Jan 28, 19 49, *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23a. SIGNATURE John H. Buchanan M.D. M. D.

23b. ADDRESS Mercy Hospital

23c. DATE SIGNED Jan 28, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Jan. 31. 1949

24c. NAME OF CEMETERY OR CREMATORY Mt. Calvery Cem.

24d. LOCATION (City, town, or county) (State) Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR Jan 31

REGISTRAR'S SIGNATURE Courtesy of Baltimore, Md.

25. FUNERAL DIRECTOR ADDRESS Elroy O. Wilson 1000 Brantly Ave.

937

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.F-90955 N 813 Registered No.

1. NAME OF DECEASED (Type or Print): HOWARD MELVIN

2. DATE OF DEATH: January 29, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1624 Eastern Avenue 2-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white		Nov. 24, 1943	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harold Melvin	Anne Powers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Harold Melvin	1624 Eastern Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	street	400 block Eastern Avenue 53-00

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
1 29 49 6p. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐ suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Carl L Reyer M.D		Jan. 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	2/1/49	New Cathedral	Frederick Rd.	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Courtney F. Williams, M.D.	John J. Connelly	Essex Md.

Correct age is especially important

VS 151

170C

G71093

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

177

Registered No. G71093

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry M. Stonesifer

2. DATE OF DEATH: Jan. 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinia Hospital

c. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2430 Frederick Ave. 70 C 4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	Widowed	Mch. 31, 1888	60	9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mch.	Western Md. R.R.	Baltimore	

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Norman Stonesifer 3010 Michigan Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the prostate c widespread metastases to all lymph nds, thoracic vertebrae, to femurs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hydronephrosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-3, 1949, *to* 1-28, 1949, *that I last saw the deceased alive on* 1-27-, 1949, *and that death occurred at* 1:25 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	Sinai Hospital	1-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/1/49	Parkwood	Taylor Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 31 1949	Huntington Williams, M.D.	Clarence F. Hoffmann 1639 Broadway.

VS 150

51B

G71094 ✓ 420 X 1 G71094

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): SEVARD I. K. SORENSEN

2. DATE OF DEATH: January 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: M California
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hayward
D. STREET ADDRESS (If rural, give location): 1070 Morrill Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Aug. 15, 1898	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chief Mate	Merchant Marine	Denmark	

13. FATHER'S NAME: Niels C. Sorensen

14. MOTHER'S MAIDEN NAME: Inge Marie Christensen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	558-03-0780	Sorensen Brothers	1140 B.St. Hayward Calif.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Generalized Arterio Sclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes X, *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR	23C. DATE SIGNED
Carl L. Reyn, M.D		1-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	1-31-49	Hayward, California	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Huntington Williams, M.D.	Wm. J. Tickner & Sons	Baltimore, Md

VS 151

94a

G71095

422.2 G71095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): MARY G. BARKLAGE | 2. DATE OF DEATH: 1/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1946 W. NORTH AVE.

c. Length of stay in Baltimore: Yrs. 15 Mos. 04 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE | B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE Md.
D. STREET ADDRESS (If rural, give location): 1946 W. NORTH AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	W	Single	April 8, 1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE		Balto Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HENRY Barklage	Margaret McCarren

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: yrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan 24 '49 to Jan 29 '49, that I last saw the deceased alive on Jan 29 '49, and that death occurred at 4 PM on the causes and on the date stated above.

23A. SIGNATURE: Henry Bowers M. D. | 23B. ADDRESS: 1604 W North Ave | 23C. DATE SIGNED: Jan 31 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	2/1/49	HOLY REDEEMER	BALTIMORE, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Courtenay for Williams, M.D.	MARTIN FAHEY & SONS	1827 W. NORTH AVE. - 17

VS 150

93D

G71096 ✓ 153 G71096

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Charles F. Almony.

2. DATE OF DEATH: Jan 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2704 N.Howard St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2704 N.Howard St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto, Maryland
D. STREET ADDRESS (If rural, give location): 2704 N.Howard St. 12-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	March 18, 1892	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Western Md Dairy	Maryland	

13. FATHER'S NAME: James Almony

14. MOTHER'S MAIDEN NAME: Lista Standiford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	215 10 2622	Mrs. Eva V. Almony	2704 N.HOWARD St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of Colon	4 yrs
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1947 *to* Jan 29, 1949, *that I last saw the deceased alive on* Jan 29, 1949, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert M. Foster M. D.	2824 St. Paul St	Jan 30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 1, 1949	Foster's	Balto Co, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Hunting to Williams, M.D.	Austin E. Donovan	3638 Roland Ave

VS. 150

46E

G71097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 422-1 G71097 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Tina Matanoski

2. DATE OF DEATH: Jan 30-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4223 Morrison Ct.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ✓

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY 1
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 4223 Morrison Ct.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Widow		70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Poland	

13. FATHER'S NAME: Wiezorek

14. MOTHER'S MAIDEN NAME: Wiezorek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		John Matusky	A. A Co Md

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

(B) Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 1, 1948 *to* Jan. 30, 1949, *that I last saw the deceased alive on* Jan. 26, 1949, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry R. Gehlert M. D.	4700 Pennington Ave.	Jan. 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/1/49	Holy Cross	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 31 1949	Entered for Williams, M.D.	Wm. J. Fialkowski	2007 Eastern Ave

VS 15D

93D

AB-15720

671098

✓ 420.0

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 671098

1. NAME OF DECEASED (Type or Print): Phillip Eckhardt

2. DATE OF DEATH: Jan. 21-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 67yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 106 W. Randal St. (Randel St.)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	1861	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cigar Maker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Carl
14. MOTHER'S MAIDEN NAME: Barbara
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Baltimore City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteroselerotic Heart Disease	?
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-27-1915 1915, *to* 1-21-49, 1949, *that I last saw the deceased alive on* 1-21-, 19 49, *and that death occurred at* 5.45 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. A. Rogers M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 1-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School
24D. LOCATION (City, town, or county) (State): JAN 31 1949

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Tunstington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 150

939

71099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 153 (47) 1099 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROSA GUNTNER	2. DATE OF DEATH Jan. 29, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 2701 E. Biddle St.	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
c. Length of stay in Baltimore 41 years (Yrs. Mos. Days)	D. STREET ADDRESS (If rural, give location) 2701 E. Biddle Street 8-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
female	white	married	Feb. 15, 1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Austria	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Emanuel Eibner	Josephine Barton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no			Urban Guntner	2701 E. Biddle St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of Sigmoid colon with cerebral metastases	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Hypertensive cardiovascular disease	5 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Sept. 3 1948	Carcinoma of Sigmoid colon - inoperable	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 5, 1948 *to* Jan 28, 1949, *that I last saw the deceased alive on* Jan. 29, 1949, *and that death occurred at* 12:20 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harold M. Gundersheimer M.D.	Riviera Apts Lake Drive	Jan. 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	2/1/49	Holy Redeemer	Belair Rd. Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JAN 31 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-03 E. Madison St.

VS 150

46 E

71100 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

241 G71100 Registered No.

1. NAME OF DECEASED (Type or Print): JOHN J. POYER, Sr.	2. DATE OF DEATH: Jan. 30, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland — B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
c. Length of stay in Baltimore: 45 years (Yrs. Mos. Days)	D. STREET ADDRESS (If rural, give location): 5018 McHuerry Street
5. SEX: male — 6. COLOR OR RACE: white — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married	8. DATE OF BIRTH: Nov. 23, 1888 — 9. AGE (In years last birthday): 60 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retire - own business — 10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Czechoslovakia — 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: unknown	14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO	17. INFORMANT — ADDRESS: Mrs. Anna M. Poyer - 5018 McHuerry St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial degeneration — DUE TO Chronic Bronchitis, Bronchiectasis — 1 yr 13 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Asthma — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Duodenal Ulcer

19A. DATE OF OPERATION: —	19B. MAJOR FINDINGS OF OPERATION: —	20 AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 6, 1935 *to* Jan. 30, 1949, *that I last saw the deceased alive on* Jan. 29, 1949, *and that death occurred at* 1A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Vincent A. Doska, M. D.	23B. ADDRESS: 845 N. Patterson Park Ave.	23C DATE SIGNED: Jan. 31 1949
24A. BURIAL, CREMATION, REMOVAL (Specify): burial	24B. DATE: 2/2/49	24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery	24D LOCATION (City, town, or county) (State): Belair Rd. Baltimore, Md.
DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949	REGISTRAR'S SIGNATURE: Huntington Williams, M.D.	25 FUNERAL DIRECTOR — ADDRESS: Schimmel Funeral Home, Inc. 2401 E. Madison Street

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 71101

BIRTH NO. B.C.H-9[illegible]523

1. NAME OF DECEASED (Type or Print): ROBERT BYRNES

2. DATE OF DEATH: Jan 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital, Balto. Md.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Glen Burnie (Hanndale)
D. STREET ADDRESS (If rural, give location): 1264 Guilford Rd. Glen Burnie Md

5. SEX: M.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Nov 19, 1947
9. AGE (In years last birthday): 1
If Under 1 Year: Months [2] Days
If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child
10B. KIND OF BUSINESS OR INDUSTRY: child
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Elmer M. Byrnes
14. MOTHER'S MAIDEN NAME: Dorothy Clark
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Hospital Records ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia (Broncho) Emphysema — Interval between onset and death: 3 weeks

DUE TO

(B) Congenital Heart disease — 14 mo

DUE TO

(C) Mongolian Idiocy — 14 mo

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Evacuation — 3 weeks

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 Jan, 1949 *to* 31 Jan, 1949 *that I last saw the deceased alive on* 31 Jan, 1949, *and that death occurred at* 9:15A m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. M. Bacon Jr. M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 2-2-49
24C. NAME OF CEMETERY OR CREMATORY: Landon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: T. W. Singleton ADDRESS: Glen Burnie, Md

157E

671102 BALTIMORE CITY HEALTH DEPARTMENT 422 671102
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): MYRTLE MAE SNYDER
2. DATE OF DEATH: January 28, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. 1 Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 25 Longeron Drive (D.J.M.)
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept., 1907
9. AGE (In years last birthday): 41 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Presser
10B. KIND OF BUSINESS OR INDUSTRY: Stadium Manu. Co.
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Harry L. Allen
14. MOTHER'S MAIDEN NAME: Ida Mae Myers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 214-24-6379
17. INFORMANT: John H. Snyder ADDRESS: 25 Longeron Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocardial degeneration
DUE TO
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE C. J. Pulaski M.D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): removal
24B. DATE: 1/31/49
24C. NAME OF CEMETERY OR CREMATORY: Elmwood Cem
24D. LOCATION (City, Town, or county) (State): Shepherdstown W. Va.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR ADDRESS: Schimunek Funeral Home, Inc. 2601-05 E. Madison Street

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mary Mc Neill

2. DATE OF DEATH: 1/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 5204 Belair Road

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md. B. COUNTY

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 5204 Belair Road

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: May 25 1897 | 9. AGE (In years last birthday): 51 yrs | If under 1 year: Months 8 Days | If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or Foreign country): Nebraska | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Mc Neill | 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Mary B. Mc Neill — ADDRESS: 5204 Belair Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: About 2 yrs

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 1 29 49 12 A m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 20, 1949, *to* Jan 29, 1949 *that I last saw the deceased alive on* Jan 29, 1949, *and that death occurred at* 12 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Mary B. Mc Neill M. D. | 23B. ADDRESS: 3601 Ailsa Ave. | 23C. DATE SIGNED: 1/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried | 24B. DATE: Feb. 1. 49 | 24C. NAME OF CEMETERY OR CREMATORY: Loudon Park | 24D. LOCATION (City, town, or county) (State): Frederick Rd - Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: John C. Miller Inc | ADDRESS: 2435 E. Oliver

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Melvina Hickman

2. DATE OF DEATH Jan. 28 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 310 N. Eden St.

c. Length of stay in Baltimore 39 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md.
D. STREET ADDRESS (If rural, give location) 310 N. Eden St. 5-01

5. SEX Femal
6. COLOR OR RACE Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct. 17. 1882
9. AGE (In years last birthday) 66 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Taylor Island Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Tom Travers
14. MOTHER'S MAIDEN NAME Maria Wheatley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT'S NAME AND ADDRESS James Hickman 310 N. Eden St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Medical Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Indef.
DUE TO
(B) Arteriosclerosis
DUE TO
(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 17, 1949, to Jan 29, 1949 *that I last saw the deceased alive on* Jan 29, 1949, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23A. SIGNATURE J Edward Fisher M. D.
23B. ADDRESS 1612 E Monument St
23C. DATE SIGNED Jan 31/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Feb. 1. 1949
24C. NAME OF CEMETERY OR CREMATORY Smithsville Cem.
24D. LOCATION (City, town, county) (State) Smithsville Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 1 1949
REGISTRAR'S SIGNATURE Hunter Van Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Elroy O. Wilson 1000 Brantly Ave.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARY L. HINTON
2. DATE OF DEATH: Jan. 30. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 49 S. Arlington Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 49 S. Arlington Ave. 1/ 0 2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	White	Widow	Oct 30, 1855	93	3	0		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME: Edward K. Tracy
14. MOTHER'S MAIDEN NAME: Mary E. Eccleston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	Royal H. Burke, 49 S. Arlington Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis with cardiac hypertrophy, myocardial degeneration and congestive failure. — 2 years
DUE TO
(B) Generalized arterio sclerosis. — many years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* December 1, 1948 *to* Jan 30, 1949 *that I last saw the deceased alive on* Jan 22, 1949 *and that death occurred at* 7.10 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm Michel M. D.	2901 Edmondson ave	Jan 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/2/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 1 1949	Winston Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Sara V Munroe

2. DATE OF DEATH: Jan. 30. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 324 E. 25th. Street

C. Length of stay in Baltimore: Yrs. Life, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 324 E. 25th. Street. 1207

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Married	Mar. 30. 1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Carville Councilman

14. MOTHER'S MAIDEN NAME: Emma Bamberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Emma M Baker ADDRESS: 324 E 25th. Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Hemorrhage	2 days.
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Myocarditis	6 yrs.
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	✓	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Neither	✓	✓

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐ ✓	✓

22. *I hereby certify that I attended the deceased from* July, 1942, *to* 30 Jan, 1949, *that I last saw the deceased alive on* 30 Jan, 1949, *and that death occurred at* 3 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	3534 Ellerslie Ave	31 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 2. 1949	Private Family Cemetery	Baltimore Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	[signature] Williams, M.D.	William Cook Inc.	1217 St. Paul St.

VS 150

93E

7213.07 ✓ 355 G7213.07

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): DOROTHY E. SURLAND

2. DATE OF DEATH: 1-30-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3708 PENNINGTON AVE
c. Length of stay in Baltimore: 6 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3708 PENNINGTON AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	SINGLE	MAY 13, '42	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	MARYLAND	

13. FATHER'S NAME: WILLIAM O. SURLAND

14. MOTHER'S MAIDEN NAME: ELLA KAISER ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		MR. GEORGE SURLAND	3708 PENNINGTON AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, bronchial — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral atrophy — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: (A) 3 days; (B) 2yrs?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1946?	Cerebral atrophy	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1, 19 49 *to* Jan 30, 19 49 *that I last saw the deceased alive on* Jan 30, 19 49 *and that death occurred at* 6 P. m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph L. Matchar, M. D.	320 Patapsco Ave	Jan 31 19 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/1/49	GLEN HAVEN	RITCHIE HIGHWAY

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Huntington Williams, M.D.	JOHN F. DENNING INC	715 LIGHT ST - 30

VS 150

107

71108 ✓ 332 G71108

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE F. SMITH

2. DATE OF DEATH: Jan. 29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4205 Stanwood ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: UNKNOWN (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write IN RAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4205 Stanwood ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	white	Widowed	1889 ?	60 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired (Fire Department)		Rock Hall, Md.	U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): unknown

16. SOCIAL SECURITY NO.

17. INFORMANT: William Smith ADDRESS: 504 FAIRVIEW Ave Catonsville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure — Interval between onset and death: 10 hrs

DUE TO

(B) Cerebral Thrombosis — 13 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Arterio-sclerosis — 10 yrs ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic myocarditis — 2 yrs ?

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 26, 1947 *to* Jan 29, 1949, *that I last saw the deceased alive on* Jan 28, 1949, *and that death occurred at* 1:52 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Joseph Guili M. D.	422 Eastern Ave	1/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/1/49	Moreland Memorial	Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 1949	Huntington Williams, M.D.	Chas. J. Evans & Son, Inc.	118 N. Mt. Royal Ave 937

VS 150

21109 ✓ 443 G71109

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MR. GEORGE CAREY LINDSAY

2. DATE OF DEATH: 1-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: — Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6212 York Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White		1-13-1872	77	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Real Estate	Real Estate	Maryland	U.S.A.

13. FATHER'S NAME: Wm. D. Lindsay

14. MOTHER'S MAIDEN NAME: Eliza Meekins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: —

17. INFORMANT: Mrs. D. E. Lindsay ADDRESS: 411 Gittings Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: (?) 36 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertronic Cardiovascular Dis.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Jan. 28, 1949, *to* Jan. 29, 1949, *that I last saw the deceased alive on* Jan. 29, 1949, *and that death occurred at* 12 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. F. Cox M.D.	Union Memorial Hospital	1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feby 1. 1949	Druid Ridge	Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Huntington Williams, M.D.	John O. Mitchell Sons	1200 Eastern Ave

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) [redacted] EDNA HALDEMAN DISNEY

2. DATE OF DEATH 1-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1615 Park avenue 17 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White		11-5-1888	60	2	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dept. Baptist Home of Md.		Pennsylvania	

13. FATHER'S NAME Lee Haldeman

14. MOTHER'S MAIDEN NAME Mary Jane Speckman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT [redacted] ADDRESS [redacted] Hospital Nurse

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-28, 1949 *to* 1-30, 1949 *that I last saw the deceased alive on* 1-30, 1949 *and that death occurred at* 7:40 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. P. Benson, Jr. M. D.	Union Memorial Hosp.	1-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 2-49	Marietta Cem.	Marietta Pa.

DATE RECEIVED BY LOCAL REGISTRAR FEB 1 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Frank H Seitz ADDRESS 814 N 36th St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Miriam Chaseman

2. DATE OF DEATH: January 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2213 Brookfield Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 42 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2213 Brookfield Ave 13-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Solomon Z Segall

14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Rev Abraham Chaseman ADDRESS: 2218 Brookfield Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio sclerosis + hypertension 10 years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1948 *to* Jan 30 1949, *that I last saw the deceased alive on* Jan 29 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Saul Cohen M. D.

23B. ADDRESS: 1804 Eutaw Place

23C. DATE SIGNED: 1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb 1, 1949

24C. NAME OF CEMETERY OR CREMATORY: Hebrew Washington Rd

24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949

REGISTRAR'S SIGNATURE: Evelington Williams, M.D.

25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS: 1124 W NorthAve

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Rosenstein

2. DATE OF DEATH: Jan. 31, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2331 Barclay St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2331 Barclay St.

c. Length of stay in Baltimore: 40 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1718 E. Fayette St. 1105

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	July 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shoemaker		Russia	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamin Rosenstein, Russia	Katie ? Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Rose Rosenstein	2331 Barclay St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of esophagus — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Carcinoma of esophagus	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Nov. *,* 1948 *, to* 31 Jan. *,* 1949 *, that I last saw the deceased alive on* 31 Jan. *,* 1949 *, and that death occurred at* 4 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. E. Nice M. D.	920 St. Paul St.	31 Jan. '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/1/49	Bnai Israel Cong.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Huntington Williams, M.D.	Levinson & Bros.	1124 W. North Av.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

151 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jacob S Klein

2. DATE OF DEATH: January 31, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3812 Wood Haven Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 3812 WoodHaven Ave

c. Length of stay in Baltimore: 55 yrs (Yrs. Mos. Days)

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 1882

9. AGE (In years last birthday): 66 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Salesman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wolf Klein

14. MOTHER'S MAIDEN NAME: Ida ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-8501

17. INFORMANT: Mrs Rose Klein ADDRESS 3812 Woodhaven Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary artery Thrombosis	4 mos
	DUE TO (B) Arteriosclerosis	Several years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Carcinoma of Stomach	6 mos
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Dec 30, 1948 *to* Jan 31, 1949, *that I last saw the deceased alive on* Jan 30, 1949, *and that death occurred at* 10:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Yaffe M. D.

23B. ADDRESS: 3101 W Belvedere Av.

23C. DATE SIGNED: 2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb, 3, 1949

24C. NAME OF CEMETERY OR CREMATORY: Hebrew Washington Blvd Baltimore Md

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949

REGISTRAR'S SIGNATURE: Martin for Williams, M.D.

25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS 1124 W North Ave

VS 150

462

71114

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.2 71114 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRY H. BROWN

2. DATE OF DEATH January 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1203 Myrtle Avenue 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Widower		80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber		St. Mary's Co., Md.	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas F. Brown	Jane Rickens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mrs. Mary Bowie 1203 Myrtle Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis

DUE TO

(B) Degeneration

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR	23C. DATE SIGNED
Carl H. Rogers M.D.		Jan. 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 2 1949	Mt. Auburn Cem.	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 1 1949	Interington Williams M.D.	Thomas A. Hensley / W. Blake 518

VS 151

93 D

✓ 162

G71115

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71115

1. NAME OF DECEASED (Type or Print): ISAAC A. MILLER
2. DATE OF DEATH: 1-31-49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctors Hospital
c. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6107 Baltimore Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Widowed		68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Poland	

13. FATHER'S NAME: Moses
14. MOTHER'S MAIDEN NAME: Eva

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Hal Miller	6107 Baltimore Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIO RESPIRATORY FAILURE

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CARCINOMA OF LUNG — INTERVAL BETWEEN ONSET AND DEATH: 1 YR.

DUE TO

(C) DIFFUSE GENERALIZED ABDOMINAL CARCINOMATOSIS.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JAN 28, 1949 *to* JAN 31, 1949 *that I last saw the deceased alive on* JAN 31, 1949, *and that death occurred at* 3:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Willard Appelquist M.D.	2511 Reisterstown Rd	2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-1-49	Mishkon Israel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

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671116

✓ 332 260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

671116 Registered No.

STATE NO.

1. NAME OF DECEASED (Type or Print): ANNA GOODMAN

2. DATE OF DEATH: 1-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3400 Carlisle Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mount Sinai Home

c. Length of stay in Baltimore: 55 Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Widow		78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Russia	

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Milton Shapiro	3400 Carlisle Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Apoplexy (Cerebral Thrombosis)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis + hypertension

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 1948 *to* Jan 31, 1949 *that I last saw the deceased alive on* Jan 30, 1949 *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jack Cohen M. D.	1804 Eutaw Place	1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-1-49	United Hebrew	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Function for Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

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G71117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

G71117

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY ELIZABETH THOMAS

2. DATE OF DEATH: Jan. 30. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4204 Kolb Ave,

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 64 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4204 Kolb Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Widowed	Sept. 3. 1867	81 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	- - -	Jacksonshir County Pa.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Bartold	Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	none	Melvin A. Thomas. 4204 Kolb Ave. Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrage	2 days
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)	Cardio - Vascular Hypertension Disease	10 years
DUE TO (C)	Arteriosclerosis	10 years
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	—	—

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 8, 1949 *to* January 30, 1949, *that I last saw the deceased alive on* January 29, 1949, *and that death occurred at* 3:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Michael J. Dausch M. D.	1 W. Chesley Ave	1-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 2. 1949	Parkwood Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 1 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC. Baltimore Md.

937

71118 Pencek X 710.0 G71118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thelma Pencek

2. DATE OF DEATH: Jan. 30 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Cecil
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cecil Chesapeake
D. STREET ADDRESS (If rural, give location): Chesapeake

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 5 yrs (Yrs. / Mos. / Days)

5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 4-23-17
9. AGE (In years last birthday): 31 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Zgmeck
14. MOTHER'S MAIDEN NAME: Jekla Zeboka

15. HAS DECEASED EVER BEEN IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: none

17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dermatomyositis — INTERVAL BETWEEN ONSET AND DEATH: about 5 yrs

DUE TO DERMATOMYOSITIS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/17 19 49 *to* 1/30 19 49, *that I last saw the deceased alive on* 1/30 19 49 *and that death occurred at* 9 15 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Bertram E. Jonas M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/2/49
24C. NAME OF CEMETERY OR CREMATORY: First Evangelical Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE, MARYLAND

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71119 ✓157 G71119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): HENRY MYERS
2. DATE OF DEATH: 1/29/49
3. PLACE OF DEATH: A. Baltimore City, Maryland 2260 SIDNEY AVE
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE MD. B. COUNTY
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ✓
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO
c. Length of stay in Baltimore: LIFETIME (Yrs. Mos. Days)
D. STREET ADDRESS (If rural, give location): 2260 SIDNEY AVE
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 3-19-1876
9. AGE (In years last birthday): 72 (If Under 1 Year: Months 10, Days 10; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work): METER READER
10B. KIND OF BUSINESS OR INDUSTRY: GAS + ELEC CO
11. BIRTHPLACE (State or foreign country): BALTO MD.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: JOHN MYERS
14. MOTHER'S MAIDEN NAME: KATHERINE BROWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. H. MYERS ADDRESS: 2260 SIDNEY AVE

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Head of Pancreas — (INTERVAL BETWEEN ONSET AND DEATH) 2 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) None

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

+ rectum (healed) (DJM) — 5 months

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1949 *to* Jan 29, 1949 *that I last saw the deceased alive on* Jan 29, 1949 *and that death occurred at* 5P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul Schonfeld M. D.
23B. ADDRESS: 720 Cathedral St
23C. DATE SIGNED: 1/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2-2-49
24C. NAME OF CEMETERY OR ~~CREMATORY~~: CEDAR HILL
24D. LOCATION (City, town, or county) (State): RICHIE HIGHWAY BALTO CO

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. H. Kembrich ADDRESS: 525 N. Fremont Ave

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 71120

1. NAME OF DECEASED (Type or Print) MICHAEL JOSEPH HANLEY

2. DATE OF DEATH January 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 323 East 30th Street

C. Length of stay in Baltimore 15 years. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 323 East 30th Street 12-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	Months	Days	If under 24 hours: Hours	Min.
male	white	Married	2-19-1891	57	11	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	U.S. Coast Guard	Du Bois Penna.	U.S.

13. FATHER'S NAME Larry J. Hanley

14. MOTHER'S MAIDEN NAME Mary May.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes. W.W. #1	169-05-0812	Mrs. Dorothy Hanley 200 E 24th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

(B) Chronic Nephritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Emil L. Beyer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Jan. 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/3/49	New Bally National	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 1 1949	(Written) for Williams, M.D.	Geo. L. Beyer Jr 1512 Hollins St

VS 151

93D

71521

BALTIMORE CITY HEALTH DEPARTMENT 340.1 G71121
CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): terry Osterday
2. DATE OF DEATH: 1/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sydenham Hospital
C. Length of stay in Baltimore: 1 day (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): timonium
D. STREET ADDRESS (If rural, give location): 105 Oakway Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	Single	5/12/42	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	0	OHIO	USA

13. FATHER'S NAME: Edward C. Osterday
14. MOTHER'S MAIDEN NAME: Mary Overbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	—	Edward C. Osterday	105 Oakway Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumococcal Meningitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
0	0	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
0	0	0

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
0 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	0

22. *I hereby certify that I attended the deceased from* 1/30 *to* 1/30, 1949 *that I last saw the deceased alive on* 1/30, 1949 *and that death occurred at* 9 05 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul Baxter, M. D.	Sydenham Hospital	1/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	Feb. 1, 1949	Parkwood Cemetery	Parkville, Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Emily for Williams, M.D.	John Devine Sons	Towson, Md.

VS 150

81a

1122

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

2040 671122

Registered No.

1. NAME OF DECEASED (Type or Print) PARRISH, MRS MARTHA F.

2. DATE OF DEATH 1-31-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL

C. Length of stay in Baltimore 50 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 847 Wellington Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	March 26, 1879	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Maryland	USA

13. FATHER'S NAME: Jarrett N. Shauck

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Griffee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs. Elizabeth L. Hastings	3527 Falls Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1. (a) Acute Myeloblastic leukemia
2. E. Coli Septicemia
3. Pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

4. Carcinoma of cervix
5. Hypertension

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-24, 1949 *to* 1-31, 1949, *that I last saw the deceased alive on* 1-31, 1949, *and that death occurred at* 140 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Julie R Hearnberger M. D.	University Hospital	1-31

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 2, 1949	Druid Ridge	Pikesville, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

48a

G71123 3 002 G71123

BIRTH NO. Registered No.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print)	ALBERT	LEE	HOWARD
2. DATE OF DEATH	January 29, 1949		

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 531 Laurens Street

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 531 Laurens Street 14-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	Colored	Married	Oct. 10, 1894	54 53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur	Unknown		

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Victoria ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Ophelia B. Howard	531 Laurens St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage Duet

DUE TO

(B) Pulmonary Tuberculosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil L. Rouzer M.D.		1-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-3-49	Mt. Auburn	Baltimore County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	[illegible] for Williams, M.D.	Wm. George A. Holland	631 Druid Hill Ave.

VS 151

1318

G71324 2 BALTIMORE CITY HEALTH DEPARTMENT G71324

BIRTH NO. 2

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Micheal Scott

2. DATE OF DEATH: 1-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 752 George St. 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	C	Single	Sept. 8, 1900	48	4	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Greenbury Scott
14. MOTHER'S MAIDEN NAME: Annie Dades

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mabel Scott, ADDRESS: 752 George St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull.
DUE TO Extensive contusion and laceration of brain.
DUE TO Fractured femur.
Fractured ribs.
Fractured facial bones.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Corner of George and Perkins St. 17/3
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 28 49 6:20 P
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/3/49	Mt. Auburn	Balto.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949
REGISTRAR'S SIGNATURE: Deputy for Philip Lee, M.D.
25. FUNERAL DIRECTOR: Wm. George H. Holland - David Hill & Co. ADDRESS: 1631

VS 151

170C

G71125 BALTIMORE CITY HEALTH DEPARTMENT 443 G71125

BIRTH NO. 1 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Julia Martin
2. DATE OF DEATH: 1/31/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 227 N. Carrollton Ave.
C. Length of stay in Baltimore: 43 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-02
D. STREET ADDRESS (If rural, give location): 227 N. Carrollton Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Married	Jan. 17, 1886	63	-	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Natural Bridge, Va	U.S.A.

13. FATHER'S NAME: Julius Combs
14. MOTHER'S MAIDEN NAME: Martha ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Mrs. Charles A. Martin	1 Carrollton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive C.V. Disease
DUE TO
(B)
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained at said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Carl L. Hoyer M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED 1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CRUMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 2/3/1949	Mt. Auburn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949 | REGISTRAR'S SIGNATURE: Tunstington Williams M.D. | 25. FUNERAL DIRECTOR: Wm. George A. Holland - Druid Hill Ave. | ADDRESS

VS 151

93D

71126 2 ✓ 443 G71126

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Grace Bush

2. DATE OF DEATH Jan. 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2418 Francis St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2418 Francis St.
C. Length of stay in Baltimore 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-03
D. STREET ADDRESS (If rural, give location) 2418 Francis St.

5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH 12/18/1865 | 9. AGE (In years last birthday) 83 | If Under 1 Year: Months 1, Days 11 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Richmond, Va
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Vandeline Bush

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Nancy Williams ADDRESS 2418 Francis St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Valvular Heart with Hypertension
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 years

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 10 1946 to Jan. 27, 1949 that I last saw the deceased alive on Jan. 29, 1949 and that death occurred at 11:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE George C. Page M. D. | 23B. ADDRESS 1516 N. Mount St. | 23C. DATE SIGNED 2-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/1/1949 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 1 1949 | REGISTRAR'S SIGNATURE Emma for Williams, M.D. | 25. FUNERAL DIRECTOR Wm. George H. Holland - David Hill Geo. | ADDRESS 768

VS 150

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671127 ✓334 671127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Louise Gettings

2. DATE OF DEATH: Jan/ 28/ 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1317 Madison Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write NAT. and give township): Baltimore Md.

c. Length of stay in Baltimore: I Year (Yrs. Mos. Days)

D STREET ADDRESS (If rural, give location): 1317 Madison Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	Col.	Widowwed	Nov. 3.1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Aubgua B.W.I.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Peters

14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT ADDRESS: Elizabeth Williams 1317 Madison Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Arteriosclerosis & hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 17 *, 1949 to* Jan. 28 *, 1949, that I last saw the deceased alive on* Jan. 26 *, 1949, and that death occurred at* ___ *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. Campbell M.D.

23B. ADDRESS: 718 Dolphin St.

23C. DATE SIGNED: 1-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb. I.1949

24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State): Arbutus Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Elroy O. Wilson 1000 Brantly Ave.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 988.0 N 979.0

G71128 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Matthews J. White

2. DATE OF DEATH: 1-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: Yrs. / Mos. / Days: All Of His Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chase Rural
D. STREET ADDRESS (If rural, give location): Eastern Ave. Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Child	Feb. 10. 1943	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mathews White
14. MOTHER'S MAIDEN NAME: Mary Earle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT / ADDRESS: Mary White Chase Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Fatty Degeneration of Liver — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Probable Phosphorous Poisoning — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Eastern Ave., Chase, Md.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1 23 49 ? m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Ingestion of foreign substance

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L. Royer M.D
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1. 31. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb.3.1949	Chase Cem.	Chase Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949
REGISTRAR'S SIGNATURE: Investigator Williams, M.D.
25. FUNERAL DIRECTOR / ADDRESS: Elroy O. Wilson 1000 Beantly Ave.

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BIRTH NO.

✓ 422.2 671129

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): James Allen

2. DATE OF DEATH: Jan 29, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland Balto md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 819 Somerset St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md
D. STREET ADDRESS (If rural, give location): 819 Somerset St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Negro	Widower	Dec 31, 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Va.	

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Beatrice Allen	819 Somerset St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C) Myocarditis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 2 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/27, 48, *to* 1/29, 1949, *that I last saw the deceased alive on* 1/29, 1949, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert L. Lefevre M.D.	832 N. Broadway St	1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 1, 1949	Mt. Calvary Cem.	A.A. County Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Huntington Williams M.D.	Mrs. Kitt G. Elliott & Daughter	1249 N Caroline St

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71130 ✓ 331

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71130

1. NAME OF DECEASED (Type or Print): Levi C. Jackson

2. DATE OF DEATH: Jan 31-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 824 Sharp St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

C. Length of stay in Baltimore: Life time (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 824 Sharp St — COUNTY 27-07
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto
D. STREET ADDRESS (If rural, give location): —

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Widower	1872	76 yrs	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	—	Balto	U.S.A

13. FATHER'S NAME: Chapman Jackson

14. MOTHER'S MAIDEN NAME: Mary —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Beatrice Jackson ADDRESS 824 Sharp

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Cerebral Hemorrhage (Right)	9 days
DUE TO (B)	Malignant Hypertension	?
DUE TO (C)	Pulmonary Congestion	7 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-22, 1949 *to* 1-31, 1949 *that I last saw the deceased alive on* 1-31, 1949, *and that death occurred at* 12 in N., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Franklin Phillips M. D.	1543 Eutaw Ave	2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-4-49	Mt Auburn	Balto.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Huntington Williams M.D.	James A Stafford	142 W. Hill St

FEB 1 vs 1949

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G71131

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

122 G71131

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Oliver, Joseph Winfield

2. DATE OF DEATH: 1/29/49 6:10A.M.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Wyman Park Drive
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S.Marine Hospital
C. Length of stay in Baltimore: 59 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1044 W. Lexington Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	married	April 22,1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber	Barber	Maryland	USA

13. FATHER'S NAME: William Oliver

14. MOTHER'S MAIDEN NAME: Maggie Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes WWI 6/18/18-6/2/19	?	Records-U.S.Marine Hospital	Balto., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Hemorrhage	
DUE TO (B)	Ruptured aneurysm of aorta	
DUE TO (C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES X NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan.18, 1949, *to* Jan.29, 1949 *that I last saw the deceased alive on* Jan.29, 1949, *and that death occurred at* 6:10A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James B. Dubbs M.D.	U.S.Marine Hospital, Balto., Md.	1/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 2, 1949	National Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Huntington Williams, M.D.	Mrs Kate R. Williams	322 N Schroeder St

FEB 1949

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71132 ✓ 162 G71132

E.S. (D.O.A.)

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Herman Robinson

2. DATE OF DEATH Jan. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospitals
C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.
D. STREET ADDRESS (If rural, give location) 828 Sarahann Street 18-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	Colored	Single	12-2-1900	48				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Robinson
14. MOTHER'S MAIDEN NAME Nannie Bennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) W.W. I
16. SOCIAL SECURITY NO
17. INFORMANT B. C. H. records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Hemorrhage
DUE TO
(B) Ca of lung with Metastases
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

CERTIFICATION APPROVED BY
for: C. J. Lubinski, M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ No ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-29- , 1949 *to* 1-29- , 1949, *that I last saw the deceased alive on* 1-29- , 1949 *and that death occurred at* 2.30 pm *from the causes and on the date stated above.*

23A. SIGNATURE C. J. Rogers M.D.
23B. ADDRESS Balto. City Hospitals
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Feb-2, 1949
24C. NAME OF CEMETERY OR CREMATORY National Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 1 1949
REGISTRAR'S SIGNATURE Instructor for Williams, Mgr
25. FUNERAL DIRECTOR Mrs Katie R. Williams ADDRESS 322 N. Schroeder St

VS 150 TO BE APPROVED BY MEDICAL EXAMINER.

477

FICATE CORRECTED 2-9-49

BIRTH NO. G71133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

092 G71133

Registered No.

1. NAME OF DECEASED (Type or Print) Isabelle Eckstorm Warren (Forrest) Eckstorm.

2. DATE OF DEATH 1 Feb 49 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
c. Length of stay in Baltimore four Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Stevensville Md R. 2 Box 6
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Stevensville Md
D. STREET ADDRESS (If rural, give location) R 2

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH H-21-1926
9. AGE (In years last birthday) 22 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) B. a. Co Md
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME J. W. Eckstorm
14. MOTHER'S MAIDEN NAME Isabelle Ireland
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT J. W. Eckstorm ADDRESS

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Yellow atrophy Liver — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Infectious hepatites
DUE TO
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 29 Jan 48, 19__, to 1 Feb 48, 19__, *that I last saw the deceased alive on* 1 Feb 48, 19__, *and that death occurred at* 1:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Richard D Hoover M. D.
23B. ADDRESS Univ. Hospital
23C. DATE SIGNED 1 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 2/2/49
24C. NAME OF CEMETERY OR CREMATORY Stevensville Md
24D. LOCATION (City, town, or county) (State) Stevensville Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 1 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR Edgar L Lane ADDRESS Church Hill Md

VS 150

125a

G71134 ✓ 420.1 G71134

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) HERMAN C. SAUTER

2. DATE OF DEATH JAN. 29 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2114 - W. Saratoga St.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 2114 W. Saratoga St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If over 1 year last birthday)	If under 1 year Months	Days	If under 24 hours Hours	Min.
Male	White	Married	6-9-1884	64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	Koester Bakery	Baltimore - Md	U.S.A.

13. FATHER'S NAME Frantz Sauter

14. MOTHER'S MAIDEN NAME Pauline Fryer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
	217-03-2135	Bernetta M. Sauter	2114 W. Saratoga

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/9, 1949 *to* 1/29, 1949 *that I last saw the deceased alive on* 1/29, 1949 *and that death occurred at* 5:40 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Bruce Longfellow M. D.	400 N. Payson St.	2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb-1st-49	Western Cemetery	Baltimore. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Hunting for Williams M.D.	F. B. Hepperd & Son	300 Eutaw Rd

VS 150

94a - 17

G71135 ✓ G71135

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 142.1

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Scholberg
2. DATE OF DEATH: 1-31-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 125 E. West St. 24 03
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): (M)
8. DATE OF BIRTH: April 5, 1894
9. AGE (In years last birthday): 54 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.): 9 26
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TELEPHONE OPERATOR
10B. KIND OF BUSINESS OR INDUSTRY: BALTO. POLICE DEPT.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Scholberg
14. MOTHER'S MAIDEN NAME: Ferdinandina Hanebe
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): YES (If yes, give war or dates of service): 1st W.W
16. SOCIAL SECURITY NO: —
17. INFORMANT: Mary Scholberg ADDRESS: 125 E. West St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma [redacted]
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-26 *,* 1948 *to* 1-31 *,* 1949 *that I last saw the deceased alive on* 1-31 *,* 1949 *and that death occurred at* 8 40 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: Mercy Hosp
23C. DATE SIGNED: 1-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2-3-49
24C. NAME OF CEMETERY OR CREMATORY: HOLY CROSS CEMETERY
24D. LOCATION (City, town, or county) (State): A.A.CO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Elizabeth Harle Inc. ADDRESS: 115 E. West St.

VS 150

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71136 ✓ 422.1 671136

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 671136

1. NAME OF DECEASED (Type or Print): ~~Mary~~ Agatino Sgroi

2. DATE OF DEATH: 1/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctors Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
114 S. East Ave. 14 2 6 10
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore, Md. 14
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	August 1, 1890	58	5	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor	Schloss Bros.	Italy	

13. FATHER'S NAME: Joseph Sgroi

14. MOTHER'S MAIDEN NAME: Roseria Furnari

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	213 09 7074	Joseph Sgroi	107 S. East Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B) Cardiac Failure — 3 days.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* 1/30, 1949, *and that death occurred at* 10:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Peter J. Jaworski M. D.	2412 E. Pratt st	1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-3-49	New Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	[illegible]	John C. Miller Inc.	2435 E. Oliver st.

VS 150

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G71137

✓ 002

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G71137

1. NAME OF DECEASED (Type or Print): August Schley

2. DATE OF DEATH: Jan. 30-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Avenue
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2441 E. Hoffman Street

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept- 17-1878
9. AGE (In years last birthday): 70 (If Under 1 Year: Months 4, Days 23; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Schley (D
14. MOTHER'S MAIDEN NAME: Margaret Frietag (D
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Baltimore City Hospitals Records- ADDRESS 4940 Eastern Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tbc. far advanced. — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Phlebothorombosis . Rt calf
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
(C) Malnutrition

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐ No

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 29- , 19 49 *to* Jan. 30 , 19 49 *that I last saw the deceased alive on* Jan. 30- , 19 49 , *and that death occurred at* 4.30A m., *from the causes and on the date stated above.*

23A. SIGNATURE: G. S. Rogers M.D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-2-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, Town, or County) (State): Frederick Rd - Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: John C. Milby Inc
ADDRESS: 2435 E. Oliver St

VS 150

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G71138

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 915, 6 N 803

G71138

Registered No.

1. NAME OF DECEASED (Type or Print) ALFRED W. PORTER

2. DATE OF DEATH January 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pikesville
D. STREET ADDRESS (If rural, give location) Pikesville State Armory

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	Jan. 21, 1905	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker

10B. KIND OF BUSINESS OR INDUSTRY U.S. National Guard

11. BIRTHPLACE (State or foreign country) New York Mills N.Y.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William J. Porter

14. MOTHER'S MAIDEN NAME Lela B. Coleman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) World War 2

16. SOCIAL SECURITY NO

17. INFORMANT William J. Porter ADDRESS 2328 E. Monument

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

DUE TO

(B) Intracranial Hemorrhage

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Kenwood Avenue 300 ft. east of Belair Rd

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 1 30 49 9.40 P.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Motorcycle into ambulance

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L. Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Jan. 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 2-3-49

24C. NAME OF CEMETERY OR CREMATORY Baltimore Natl

24D. LOCATION (City, town, or county) (State) Frederick Rd - Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 1 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Ralph Mulligan Inc.

ADDRESS 2435 E. Oliver St

VS 151

170c

Correct Age is Opening Important. Inquiries [illegible]

G71139 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.2 G71139 Registered No.

1. NAME OF DECEASED (Type or Print): (MATHIO) MASEO PINKNEY (PINKEY)

2. DATE OF DEATH: January 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: A.A. County
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~
D. STREET ADDRESS (If rural, give location): 6003 Belgrove Road (dim)

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: July 4, 1904
9. AGE (In years last birthday): 44 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10B. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): South Caroline
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Isrcal Pinkney
14. MOTHER'S MAIDEN NAME: Elizabeth Henson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Rosabelle Pinkney ADDRESS: 6003 Belgrove Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocardial Degeneration
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: C. J. Lubinski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 2/1/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto City

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. S. Brown & Son ADDRESS: 1048 W Montgomery St

VS 151

92D

G71140 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94.8 991 Registered No. G71140

1. NAME OF DECEASED (Type or Print): ROBERT E. STUNKARD
2. DATE OF DEATH: January 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 409 South Caton Avenue 70-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
male	white	married	July 3, 1882	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Flavor Extracts	Penna	

13. FATHER'S NAME: Easton Stunkard
14. MOTHER'S MAIDEN NAME: Elizabeth Schrader

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
No	none	Clarence Stunkard N. Bouldin St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Strangulation by Hanging — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	cemetery	Loudon Park Cem. 3801 Frederick Ave.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21F. HOW DID INJURY OCCUR?
1- 29 49 ? m.		Hanged self from treet

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Carl L. Boyer M.D.	☒ / ☐	Jan. 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 2nd 1949	Loudon Park Cem	Fredk. Ave Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
FEB 1 1949	Huntington Williams, M.D.	Dill Bros. 3109 Frederick Ave

VS 151

164a

G71141 — X,140 — G71141

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JOHN WILLIAM HUMMEL

2. DATE OF DEATH: Jan. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 8926 Clement Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Single	12/17/98	50	1	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Hummel
14. MOTHER'S MAIDEN NAME: Anna Christian
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WWII-8/6/42-11/24/45
16. SOCIAL SECURITY NO: 215-07-0220
17. INFORMANT: Records, US Marine Hospital, Balto, Md. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hemorrhage, right common carotid artery, due to	One week
DUE TO (B)	carcinoma lip	6 yrs.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: 7/22/47
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of lip
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 16, 1947, *to* Jan. 29, 1949, *that I last saw the deceased alive on* Jan. 29, 1949, *and that death occurred at* 5:20 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson, Sr. Surgeon, Clinical Director, M.D.
23B. ADDRESS: US Marine Hospital, Balto, Md.
23C. DATE SIGNED: 1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 2/3/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR (ADDRESS): Ullrich Funeral Home-2008 Orleans St.

VS 150

45a

G71142 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.0 G71142 Registered No.

1. NAME OF DECEASED (Type or Print): William Adam Owens
2. DATE OF DEATH: Jan. 30, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 500 Dorchester Road.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	white	married	11-24-77	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer Oper.
10B. KIND OF BUSINESS OR INDUSTRY: Balto Transit
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Richard Owens
14. MOTHER'S MAIDEN NAME: Clara J. Wright
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO. 213-05-9078
17. INFORMANT: Franklin B. Owens ADDRESS: Catonsville 28

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Occlussion
DUE TO
(B) Arterio-sclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Generalized Arteriosclerosis.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 23 1949, *to* Jan 30, 1949, *that I last saw the deceased alive on* Jan 30, 1949, *and that death occurred at* 5 20 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Philip A. Peter M.D. M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: Jan 31 '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 2 49
24C. NAME OF CEMETERY OR CREMATORY: Salem Ch. Cem.
24D. LOCATION (City, town or county) (State): Catonsville 28 Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Edward S. MacNabb ADDRESS: Catonsville 28

VS 150

93D

✓ 581.0

71143
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71143

1. NAME OF DECEASED (Type or Print): CHARLES JAMES FERRARO
2. DATE OF DEATH: 1-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial
C. Length of stay in Baltimore: Yrs. — Mos. — Days —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1004 Eastern ave.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	April 4, 1892	56 57	8	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Street Paver - Foreman	—	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Vincent Ferraro
14. MOTHER'S MAIDEN NAME: Theresa ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO
—	—	

17. INFORMANT: Mrs. Elizabeth Ferraro — same — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of liver
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-29, 1949 *to* 1-29, 1949 *that I last saw the deceased alive on* 1-29, 1949, *and that death occurred at* 6:12A m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. P. Benson, Jr. M. D. | 23B. ADDRESS | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan Feb 4 1949	Holy Redeemer.	Belair Road.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Hunting for Williams Asst	Mendel J. Hyppel	312 S. Highland ave

VS 150

124 B

✓ 420.1 G71144

G71144
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): CLARA MAY HOUSTON
2. DATE OF DEATH: Jan. 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4315 Springdale Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4315 Springdale Ave. 28-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	May 29, 1873	75 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—		Baltimore, Md.	

13. FATHER'S NAME: Samuel Houston
14. MOTHER'S MAIDEN NAME: Mary Graham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Mrs. Helen H. Littleton	4315 Springdale Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C) Malnutrition

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 days

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 27, 1949 *to* Jan 31, 1949, *that I last saw the deceased alive on* Jan 31, 1949, *and that death occurred at* 7 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Dr Thos J Abbott M. D.
23B. ADDRESS: 4509 Liberty Heights Ave
23C. DATE SIGNED: 2-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/2/49	Greenmount Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	[illegible]	WM. J. TICKNER & SONS	Balto., Md.

VS 150

94a

G71145 ✓ 442 G71145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARY ELIZABETH MICHAL

2. DATE OF DEATH: Jan. 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 231 N. Monroe St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 231 N. Monroe St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
F	W	Widowed

8. DATE OF BIRTH: Dec. 29, 1856

9. AGE (In years last birthday) 89 Yrs. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10B. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: August Tentz

14. MOTHER'S MAIDEN NAME: Mary Stephan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO
No		No

17. INFORMANT — ADDRESS: Miss Cecilia Michal 231 N. Monroe St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coma (Chronic Nephritis) — INTERVAL BETWEEN ONSET AND DEATH: Jan 27 - Jan 30 - Days

DUE TO

(B) Cardio - Vascular Renal disease — -

DUE TO

(C) Arterio - Sclerosis. — -

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 3, 1949 *to* Jan 30, 1949, *that I last saw the deceased alive on* Jan 29, 1949, *and that death occurred at* 3:00 A. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis H. Krumen M.D.

23B. ADDRESS: 722 No. Kenwood ave

23C. DATE SIGNED: 1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	2/2/49	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 1 1949

REGISTRAR'S SIGNATURE: Hunting for Williams M.D.

25. FUNERAL DIRECTOR — ADDRESS: WM. J. TICKNOR & SONS INC. BALTO. MD.

VS 150

1310

G71146 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 447 G71146 Registered No.

1. NAME OF DECEASED (Type or Print): Eleanor Anna Rowe

2. DATE OF DEATH: 1/31/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE: Md. B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 607 N. Linwood Avenue 7-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Fe.	White	Married	March 17, 1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hwfe.	Housewife	Baltimore, Maryland	

13. FATHER'S NAME: William H. Sewell

14. MOTHER'S MAIDEN NAME: Catherine Coscoone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Martin L. Rowe	607 N. Linwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertension

DUE TO

(C) (Post-Operative Sympathectomy)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/19/49	Hypertension: Sympathectomy performed.	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/17/ , 1949, *to* 1/31/ , 1949 *that I last saw the deceased alive on* 1/31/49, 19 , *and that death occurred at* 3:20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William A. Roelken, M. D.	1400 N. Caroline Street	1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/4/49	Oak Lawn Cem.	Balto. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	[illegible] for Williams, M.D.	John A. Mosan	3000 E. Baltimore St

VS 150

734

G71147

BALTIMORE CITY HEALTH DEPARTMENT 010

CERTIFICATE OF DEATH

Registered No. G71147

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Zora Hamilton

2. DATE OF DEATH: Jan. 31, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland (Hopkins Hosp Opd)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Pr Georges
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairmont Hgts.
D. STREET ADDRESS (If rural, give location): 61 Addison Chapel Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored		12-22-28	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		D. C.	

13. FATHER'S NAME: Roosevelt Hill

14. MOTHER'S MAIDEN NAME: Caudeela Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous meningitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Tuberculous mediastinal adenitis

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10/20 1948 *to* 1/31 1949, *that I last saw the deceased alive on* 1/31 1949, *and that death occurred at* 10 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D Jackson M. D.	JOHNS HOPKINS HOSPITAL	2-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, [illegible])
	2-1-49		Washington [illegible]

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR
FEB 1 1949	Huntington Williams M.D.	Henry S. Washington [illegible]

VS 150

467 N. Ash. N. W. 14

Profleister Potapsco 3025 ✓ 260 450.0 G71148

G71148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Johanna Volny

2. DATE OF DEATH Jan 31, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1502 Hazel st

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural

c. Length of stay in Baltimore 41 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1502 Hazel st

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	May 12 1866	82	8	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Austria	U.S.

13. FATHER'S NAME Valentine Hoovabog

14. MOTHER'S MAIDEN NAME Mary Stavinova

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Antonette Simms	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acidosis

DUE TO

(B) diabetes mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) arthritis deform

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1949 to Jan 31 1949 *that I last saw the deceased alive on* Jan 30, 1949, *and that death occurred at* 1:30 a m, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip N Kesatis M. D.	3025 Potapsco Ave	1-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 2 49	Holy Cross Cem	G. G. County

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Huntington Williams	Frank Brockbon	

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Parthenia Jones

2. DATE OF DEATH Jan. 30-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2205 N. Howard St

C. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 2205 N. Howard St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	W	Dec. 25-1893	55	1 / 5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Charlotte Court House Va

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Beverly Moseley

14. MOTHER'S MAIDEN NAME Susan Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Ruth Coleman ADDRESS 2205 N. Howard

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio. Renal Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 10 — 19 48, *to* Jan 30 19 49, *that I last saw the deceased alive on* 19 *and that death occurred at* 6:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE Thos. J. Gleeson M. D. | 23B. ADDRESS 2329 Greenmount | 23C. DATE SIGNED Jan 31-49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE 2-2-49 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary | 24D. LOCATION (City, town, or county) (State) A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 2 1949 | REGISTRAR'S SIGNATURE Juanita for Williams, M.D. | 25. FUNERAL DIRECTOR Samuel W. Sullivan Jr. ADDRESS Balto. Md.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) George Benjamin Benner

2. DATE OF DEATH Jan. 31st 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1118 N. Milton Ave.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1118 N. Milton Ave 8-03

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	July 13th 1890	58	6	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bartender	Restaurant	Balto. Md	U.S.A.

13. FATHER'S NAME Benjamin Benner

14. MOTHER'S MAIDEN NAME Jenny Waters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	213-10-5850	W. H. Smitzel	4100 Briar Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio Vascular Disease..

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH -

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* May, 1944 *to* Jan 31, 1949 *that I last saw the deceased alive on* ____ 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. R. Stevens M.D.	3400 Eastern Ave	2/1/49

24A. ~~BURIAL, CREMATION, REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	2-3-49	Balto.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Courtney for Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 150

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Lavinia Moon

2. DATE OF DEATH: Feb. 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital 4940 Eastern Ave.

c. Length of stay in Baltimore: 3 months (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3122 Clearview Ave.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: July 11, 1904
9. AGE (In years last birthday): 44 yrs. (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Obe Larson

14. MOTHER'S MAIDEN NAME: Elizabeth Palter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:

17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis Far Advanced — (Interval between onset and death): ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Tuberculosis Percarditis And Tuber Culois Cuepyemia

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-25, 1948 *to* Feb. 1, 1949, *that I last saw the deceased alive on* Feb. 1, 1949, *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: M. D.
23B. ADDRESS: B. C. H. 4940 Eastern Ave.
23C. DATE SIGNED: Feb. 1, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/3/49
24C. NAME OF CEMETERY OR CREMATORY: Druid
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilson & Cole ADDRESS: 1217 E. Lond St

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Victorene (Mrs) Harward

2. DATE OF DEATH: 1 February 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 4511 Schenley Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): None.
c. Length of stay in Baltimore: 50 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4511 Schenley Rd. 27-14

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Nov. 2 1878
9. AGE (In years last birthday): 70 (If under 1 Year: Months — Days —; If under 24 Hours: Hours — Min. —)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Bel Air Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Harward
14. MOTHER'S MAIDEN NAME: Elizabeth McFadden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: Fannie E Harward — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	3 wks.
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Hypertensive Cardiovascular Renal disease	3 mo.
DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	None	

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1, 1948, *to* February 1, 1949, *that I last saw the deceased alive on* 31 Jan, 1949, *and that death occurred at* 8 [illegible] A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Johnson M.D.
23B. ADDRESS: 5202 Harford Rd
23C. DATE SIGNED: Feb 1 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/4/49
24C. NAME OF CEMETERY OR CREMATORY: St Mary's
24D. LOCATION (City, town or county): Norwood Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: 1949
REGISTRAR'S SIGNATURE: Torrington Williams M.D.
25. FUNERAL DIRECTOR: Wilhelm Bros.
ADDRESS: 1219 Park St

VS 150

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

N99 Registered No.

REPLACED BY

1. NAME OF DECEASED (Type or Print) Henry E. Tolson

2. DATE OF DEATH 2/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1804 Clifton Ave. 15-14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Divorced	Sept 24. 1888	60	4	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Kent Island Md	

13. FATHER'S NAME Joseph H Tolson

14. MOTHER'S MAIDEN NAME Mary Norman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Joseph Tolson	1804 Clifton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation by hanging
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	1804 Clifton Ave.

21D. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐	NOT WHILE AT WORK ☒	21F. HOW DID INJURY OCCUR?
2	1	49	5 A. m. approx.			Hanged self with rope

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D		2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/5/49.	Stevensville	Stevensville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Huntington Williams, M.D.	Wilson Funeral Home	624 Lombard

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MEDICAL EXAMINERS CASE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 900.0 G71154

N 803.2

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): EMMA PARKER

2. DATE OF DEATH: Jan. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brooklyn
D. STREET ADDRESS (If rural, give location): 1425 Patapsco Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. Gen. Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Married	Oct 3, 1876	72	3	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Maryland	U.S.

13. FATHER'S NAME: Joseph Jowlen

14. MOTHER'S MAIDEN NAME: Sarah Greenstreet

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Robert L. Parker	1427 Patapsco Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Fractured Skull	21 Hrs
	DUE TO Fall	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Fracture of Facial Bones	21 Hrs
	DUE TO Fall	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

CERTIFICATION APPROVED BY
A. B. Merrill M.D.
for: W. H. Kammer, Jr., M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
None	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home	1425 Patapsco Ave. 25/5

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
1-29-49 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fall down stairsteps (agmw)

22. *I hereby certify that I attended the deceased from* Jan 29, 1949 *to* Jan 30, 1949, *that I last saw the deceased alive on* Jan 30, 1949, *and that death occurred at* 3:35 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John M. Bledsoe Jr M. D.	South Balto. Gen. Hosp.	Jan 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/2/49	Cedar Hill	Annapolis Blvd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Evelyn Williams M.D.	John F. Denny Inc	710 Light St

VS 150

186a

71155 ✓ 443 G71155

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): GOLDSCHMIDT, MRS MARY

2. DATE OF DEATH: 1-31-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 74 yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 2209 Pelham Ave 9-2

5. SEX: Female | 6. COLOR OR RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 4-1869 | 9. AGE (In years last birthday): 79 | If Under 1 Year: Months 6, Days 27 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm Saunder

14. MOTHER'S MAIDEN NAME: Margaret Saunder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO

17. INFORMANT: Mr. Wm Gabler | ADDRESS: 2209 Pelham Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive C.V. Disease

DUE TO

(C) Biliary obstruction - Post operative Pancreatic necrosis -

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-10, 1949, *to* 1-31, 1949, *that I last saw the deceased alive on* 1-31, 1949 *and that death occurred at* 9:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Arlie R Mandlebaum M. D. | 23B. ADDRESS: University Hospital | 23C. DATE SIGNED: 1-31

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 1-4-49 | 24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn | 24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: FEB 2 1949 | REGISTRAR'S SIGNATURE: Hunter for Williams, M.D. | 25. FUNERAL DIRECTOR: Philip Herwig Sons | ADDRESS: 2024 Orleans St

VS 150

937

71156 ✓ 581.1 G71156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARIAN A. HOPPER

2. DATE OF DEATH February 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1618 Harford Avenue

C. Length of stay in Baltimore 47 Yrs. 4 Mos. 29 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1618 Harford Avenue 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	If under 1 year: Days	If under 24 hours: Hours	If under 24 hours: Min.
female	white	Married	Sept. 3, 1901	47 49	4	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House work	at Home	Baltimore, Md.	U.S.A.

13. FATHER'S NAME John A. Sherman

14. MOTHER'S MAIDEN NAME Margaret Ann Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	Mrs. Regina M, Dalzlish	Washington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of liver

DUE TO History of Chronic alcoholism.

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George L. Merrill M.D.		Feb. 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 4, 1949	New Cathedral Cemetery	4300 Old Frederick Rd Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Assistant for Williams, M.D.	Elmer W. Conklin	924 E. Eager St.

VS 151

124a

671157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

584 671157 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Weller MRS CARRIE / SCHAALE

2. DATE OF DEATH Feb. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 6 EAST REED ST.

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED
8. DATE OF BIRTH 25 MARCH 187[illegible]
9. AGE (In years last birthday) 71
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) BALTIMORE
12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Frank WELLER
14 MOTHER'S MAIDEN NAME Dorothy Spittle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT BERTHA S. HOTT 5900 BRACKEN RIDGE AVE BALTO #12

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) BILIARY CIRRHOSIS & NECROSIS — INTERVAL BETWEEN ONSET AND DEATH: Two wks
DUE TO (B) CHRONIC CHOLECYSTITIS WITH CHOLELITHIASIS AND CHOLEDOCHOLITHIASIS — 5 YEARS
DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HYPERTENSIVE CARDIOVASCULAR DISEASE 10 YRS OBESITY, DIABETES MELLITUS, MILD

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 18 JAN 1949 *to* 01 FEB 1949, *that I last saw the deceased alive on* 01 FEB 1949, *and that death occurred at* 8 05 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Donald F. Eugland M. D.
23B. ADDRESS Maryland Gen Hosp
23C DATE SIGNED 01 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/4/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
24D LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 2 1949
REGISTRAR'S SIGNATURE Hunter for Williams, M.D.
25 FUNERAL DIRECTOR WM. J. TICKNER & SONS
ADDRESS Balto., Md.

VS 150

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71158

BALTIMORE CITY HEALTH DEPARTMENT 155

CERTIFICATE OF DEATH

G71158

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Estelle May Bost

2. DATE OF DEATH Feb 1-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1514 Pentridge Rd. Apt. 162

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	married	Feb. 3, 1923	25 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Saleswoman	Hochschild Kohn & Co	Baltimore, Md.	

13. FATHER'S NAME Walter Sommer

14. MOTHER'S MAIDEN NAME Stella M. Grady

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	W.W. #2		Mr. Luther L. Bost	1514 Pentridge Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Primary Ca of Liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/26 1948, to Feb 1, 1949, *that I last saw the deceased alive on* 2/1, 1949, *and that death occurred at* 3 10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Edward J. Sabalini M. D.

23B. ADDRESS St Agnes

23C. DATE SIGNED 2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/5/49	Moreland Mem. Pk.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 2 1949

REGISTRAR'S SIGNATURE Louise Williams, M.D.

25. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

VS 150

46F

G71159
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.1 G71159
Registered No.

1. NAME OF DECEASED (Type or Print): John J. GAHAGAN Jr
2. DATE OF DEATH: Feb. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 428 E. 20th St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. (Baltimore) B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 428 E. 20th St. 12-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Single	May 19, 1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Policeman	(Baltimore City)	Baltimore Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John J. Gahagan Sr.	Bridget Gortland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Spanish - American War		Mrs. Mae Patricia Detoris 428 E. 20th St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic cardiovascular disease.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* _____ (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George L. Merrill M.D.		2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 3/49	New Cathedral	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Deputy for Williams M.D.	Chas. J. Evans & Son	118 W. Mt. Royal Ave 93

VS 151

Type or write in ink. Spelling is important. Please write the name of deceased clearly and legibly.

G71160 JL* 31548

CERTIFICATE CORRECTED 8-26-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 2.1 G71160 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry M. Butler

2. DATE OF DEATH: Feb. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave. Baltimore City Hospitals

c. Length of stay in Baltimore: 9 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 606 Scott St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	Widowed	Mar. 1, 1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Frank

14. MOTHER'S MAIDEN NAME: Henrietta Pope

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: B. C. H. Records, ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		(INTERVAL BETWEEN ONSET AND DEATH)
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchopneumonia	10 days
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) H. A. S. C. V. D.	15 yrs.
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ No ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-11-38 *to* Feb. 1, 1949, *that I last saw the deceased alive on* Feb. 1, 1949, *and that death occurred at* 10.14 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	Baltimore City Hosp.	Feb. 1, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-3-49	Principio Mem. Park	New Port News

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Huntington Williams, M.D.	John C. Miller Inc.	2425 E. Oliver St.

VS 150

correct age is especially important. Physicians: please write the cause of death plainly.

937

G71161 ✓ 450.0 G71161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Marion H. Brennan

2. DATE OF DEATH Jan 31. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5608 Winthrop Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 40 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN Balto (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 5608 Winthrope Ave 57-44

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 9st 1879
9. AGE (In years last birthday) 69 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Washington D. C
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel Hunt
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT John E. Brennan 5608 Winthrope ave ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Senile Arteriosclerosis — 3 years.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. senility over

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 20 1949 *to* Jan 30 1949 *that I last saw the deceased alive on* Jan 30 1949 *and that death occurred at* 2.00 Pm *from the causes and on the date stated above.*

23A. SIGNATURE Charles J. Brennan M.D.
23B. ADDRESS 5217 Harford Rd
23C. DATE SIGNED 2-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Feb 2nd 1949
24C. NAME OF CEMETERY OR CREMATORY Balto National
24D. LOCATION (City, town, or county) (State) Fredrick Road

DATE RECEIVED BY LOCAL REGISTRAR FEB 2 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR Leo S. Cook ADDRESS 1705 N. Patterson Park ave

VS 150

108

71162

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

H22.1 G71162

Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES HUBBE — HOPPE (CHARLES) NAEVERS)

2. DATE OF DEATH: January 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1048 N. Broadway 7-04

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 1, 1867

9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min.: 81 (djm)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Elizabeth Yemmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Mary Thomas — ADDRESS: 1813 N. Montford Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp, & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE C. Schaefer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-4-49

24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): E. North Avenue Extended

DATE RECEIVED BY LOCAL REGISTRAR: FEB 2 1949

REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.

25. FUNERAL DIRECTOR: LEO G. COOK — ADDRESS: 1703 N. Patterson Park Ave.

VS 151

93D

671163

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.1 671163

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lena H. Elliott

2. DATE OF DEATH: Jan. 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3015 Grayson St.,
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3015 Grayson St., 16 07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	March 11, 1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	--	Maryland	

13. FATHER'S NAME: Louis Knauss

14. MOTHER'S MAIDEN NAME: Louise Knott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	Miss Mamie L. Elliott	3015 Grayson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerotic typehart disease with hypertrophy + myocardial degenerations and congestive failure. — INTERVAL BETWEEN ONSET AND DEATH: Several years.

DUE TO

(B) generalized arteriosclerosis.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1, 1949 *to* Jan 31, 1949, *that I last saw the deceased alive on* Jan 31, 1949, *and that death occurred at* 6.00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm Michel M. D.	7901 Edmondson Ave	Feb 1 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-4-49	Loudon Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Huntington Williams, M.D.	J. Howard Strong	3207 W. North Av

VS 150

93D

71164

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1 71164

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) MAYLON EDWARD BARRETT

2. DATE OF DEATH 1-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kernan Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2200 Mosby Ave., 2803

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	May 15, 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer	Hospital	Maryland	

13. FATHER'S NAME: Grafton Barrett

14. MOTHER'S MAIDEN NAME: Elizabeth Gill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	W.W. 1	219-20-9897	Richard Ginnamon	2200 Mosby Ave.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Carl L Reyer M.D.		31 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-3-49	New Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Cuntis Stor Williams, M.D.	G. Howard Strong	3207 W. North Ave.

VS 151

94a

71165

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153 Registered No. 71165

BIRTH NO.

1. NAME OF DECEASED (Type or Print) [redacted] William A. Jones

2. DATE OF DEATH Feb 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland De. Balto Gen Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY Anne

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto. Gen. Hosp

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lansdowne Ranger Glen Burnie R.F.D.

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) Railroad Ave Glen Burnie R.F.D.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	March 9, 1903	45 Yrs	10 / 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Operator	Fertilizer Chemical	Balto Md	U.S.

13. FATHER'S NAME William A. Jones Sr

14. MOTHER'S MAIDEN NAME Lucy Bolt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	Yes		Mrs Pauline A. Jones	Glen Burnie Rockhurst Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Carcinoma of splenic flexure of colon — INTERVAL BETWEEN ONSET AND DEATH: about 1 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-31 1949 *to* 2-1 1949 *that I last saw the deceased alive on* 2-1 1949 *and that death occurred at* 4 (19) m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marvin W. Davis M. D.	West Balto Gen Hosp	2-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 4 1949	Glen Haven	Anne Arundel Co

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Acting for Williams M.D.	H. Howard Evans	16 Church St

VS 150

46E

71166 ✓ 442 G71166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Dr. BERNARD N. HATCHER

2. DATE OF DEATH: 29 Jan. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Provident Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: 30 Yrs. — More Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 437 N. Calhoun St 19 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	Negro	Married	20 Nov. 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Physician	—	Richmond, Va	U. S. A

13. FATHER'S NAME: William H. Hatcher

14. MOTHER'S MAIDEN NAME: Martha Winston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	Mrs. Rachel Hatcher	437 N. Calhoun St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive cardio-vascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Sept 15 1948, *to* Jan 29, 1949 *that I last saw the deceased alive on* Jan 29, 1949 *and that death occurred at* 12½ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James D. Carr M. D.	515 Mulberry St	2.1.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 3, 1949	Arbutus	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Huntington Williams, M.D.	George D. Kelson	1202 Pennsylvania Ave

VS 150

131a

671167 411 671167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Henrietta Medinger
2. DATE OF DEATH: 1/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 600 4 Edna Ave #4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	April 12, 1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Maryland	

13. FATHER'S NAME: Augustus C. Medinger
14. MOTHER'S MAIDEN NAME: Hannah R. Pfaff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lorana Medinger — ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart disease
DUE TO Aortic stenosis and calcification of aortic valve.
(B) Possible pulmonary infarct.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/25/49 19 *to* 1/30/49 19 *, that I last saw the deceased alive on* 1/30 *, 1949, and that death occurred at* 5:35 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry V. Chase M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: Feb 2 49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount
24D. LOCATION (City, town, or county) (State): BALTO.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 2 1949
REGISTRAR'S SIGNATURE: Funeral for Williams, Mill
25. FUNERAL DIRECTOR: L. Heemann — ADDRESS: 325 S. Broadway

VS 150

92C

G71168 BALTIMORE CITY HEALTH DEPARTMENT 162 G71168
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Mr. Andrew J. Baker
2. DATE OF DEATH 2/1/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Union Memorial Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital
c. Length of stay in Baltimore 7 Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore 12 532 Richwood Ave.
C. CITY OR TOWN Balt. 12 (If outside corporate limits, write RURAL and give township) 27-10
D. STREET ADDRESS (If rural, give location) 532 Richwood ave., Balt. 12 Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	white	M	Sept. 23, 1877	71	4 / 8	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. P. Cana Co.
10B. KIND OF BUSINESS OR INDUSTRY Packer
11. BIRTHPLACE (State or foreign country) Balt., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Baker
14. MOTHER'S MAIDEN NAME Elizabeth Miskimen
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown
16. SOCIAL SECURITY NO. 216-01-5608
17. INFORMANT Miss Ella Siffring ADDRESS 323 Overbrook Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchiogenic Carcinoma	5 months
	DUE TO (B) Metastasis	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Uremia	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 26, 1948, to Feb 1, 1949, that I last saw the deceased alive on Jan 31, 1949 and that death occurred at 5:45 A m., from the causes and on the date stated above.

23A. SIGNATURE Charles H. Watts Jr. M.D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 2-3-1949
24C. NAME OF CEMETERY OR CREMATORY PARKWOOD
24D. LOCATION (City, town, or county) (State) BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR FEB 2 1949
REGISTRAR'S SIGNATURE Registrar for Baltimore, Md.
25. FUNERAL DIRECTOR H. W. JENKINS & SONS CO. ADDRESS 4905 YORK RD.

FEB 2 1949

47c

G71169 ✓ 422.2 G71169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Elizabeth H Findlay French

2. DATE OF DEATH Feb 1 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 218 Ridgewood Rd

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY ✓
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 218 Ridgewood Rd

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W	widowed	Nov 18 1856	92	2 15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Balto. Md	USA.

13. FATHER'S NAME Charles Findlay

14. MOTHER'S MAIDEN NAME Elizabeth H. Boyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		H. Findlay French	3902 Canterbury Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis - Stenosis — INTERVAL BETWEEN ONSET AND DEATH: 0 months

DUE TO Myocardial Degeneration — 1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1930 *to* Feb 1st 1949, *that I last saw the deceased alive on* Feb 1st 1949, *and that death occurred at* 11:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. A. Shotland M. D.	340 N. Calvert St. Balto Md	Feb 2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 3 1949	Green Mount	Balto, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Huntington Williams, M.D.	Henry N. Jenkins (Asst)	4905 York Rd

VS 150

935

G71170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.1 G71170
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE ROSS PENNY

2. DATE OF DEATH: February 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 700 Fleet Street
C. Length of stay in Baltimore: unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 834 Eutaw Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	W	Sept 29 1890	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Screening etc.
11. BIRTHPLACE (State or foreign country): unknown
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 106-09-7079
17. INFORMANT
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 2-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 4/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 2 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Henry W. Jenkins Sons Co
ADDRESS: 4905 York Rd

935

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71171

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163 G71171 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Graham, John H. Garham
2. DATE OF DEATH: 1/29/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Gen. Hosp. + Spo
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 21-01
c. Length of stay in Baltimore: Yrs. Mon. Days
D. STREET ADDRESS (If rural, give location): 534 W. Cross St Cross St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Col.	Married	Dec. 31. 1904	44 43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	B. & O. R. R.	Waycross Ga	U. S. A.

13. FATHER'S NAME: John + Graham
14. MOTHER'S MAIDEN NAME: Maria P

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Nonie Graham 2-2-49	1115 Gapeland St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

DUE TO

(B) Bronchiogenic Carcinoma — 1 month

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/5/49	Squamous Cell Carcinoma Neck (Metastatic?)	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 24 Dec, 1948, to 29 Jan, 1949, that I last saw the deceased alive on 29 Jan 1949, and that death occurred at ___ m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	SBGH	1/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 2-49	Mt. Calvary Cem.	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 2 1949	Huntington Williams M.D.	Elwood J. Wilson 1000 Brantley Ave

VS 150

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G71172 ✓002 G71172

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Mills

2. DATE OF DEATH: 1/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1145 - Whatcoat St. 16-07

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 22, 1903
9. AGE (In years last birthday): 45 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newspaper Salesman
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME: Sarah ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-14-7626
17. INFORMANT: Annie Mills — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Influenza Pneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Edward L. Pope M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/3/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town or county) (State): Cedar Hill Md.
25. FUNERAL DIRECTOR — ADDRESS: A. Halstead - 918 - Druid Hill Ave 13 B

DATE RECEIVED BY LOCAL REGISTRAR: FEB 2 1949
REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.

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BIRTH NO. G71173

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 420 G71173

1. NAME OF DECEASED (Type or Print): Karolina Tokarz

2. DATE OF DEATH: Feb,2-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore,Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 2928 E.Baltimore St
c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 2928 E.Baltimore Street 6-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Aug,8th.1858	90		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Poland	

13. FATHER'S NAME: Mikolaj Zwolinski

14. MOTHER'S MAIDEN NAME: Katarzyna Chmura

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Mrs.Mary Dashkivich	2928 E.Baltimore S

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		(INTERVAL BETWEEN ONSET AND DEATH)
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	2-1-to 2-2 1949
DUE TO (B)	Chronic Myocarditis	1/1940
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1, 1940 *to* Feb. 2, 1949, *that I last saw the deceased alive on* Feb 1, 1949, *and that death occurred at* 1:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William J. Brauer M. D.	801 N Kenwood Ave	2/2.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb,5-1949	St.Stanislaus	Baltimore,Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Hunter for Williams, M.D.	George A. Weber	705 La Ann st

VS 150

G711'74

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

144 G711'74

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) JOHN ROBERT MULVANEY

2. DATE OF DEATH Feb. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 204 S. Pagley St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	9/25/93	55	4	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plumber		W.Va.	USA

13. FATHER'S NAME John Mulvaney

14. MOTHER'S MAIDEN NAME Helen White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	WW I		Records- US Marine Hospital	Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of the mouth	Unknown
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO	Subdural hematoma, right	Unknown
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 22, 1948 *to* Feb. 1, 1949 *that I last saw the deceased alive on* Feb. 1, 1949 *and that death occurred at* 4:40 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Sr. Surgeon M. D.	US Marine Hospital, Balto. Md.	2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 4/1949	Baltimore National Cemetery 5501 Frederick Ave	(Balt. Md)

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 2 1949	Timothy [illegible] Williams, M.D.	Frank Dellinger	322 S. High St.

Vs 150

45c

CM. 11810 G71175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

570.2 G71175

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret E. Dooley

2. DATE OF DEATH: 1-31-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 25 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore MD.
D. STREET ADDRESS (If rural, give location): 1115 W. Lombard Street 18-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	July 26-1872	76 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VA. (Bedford)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Granville Turner

14. MOTHER'S MAIDEN NAME: Mildred Angle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: none

17. INFORMANT: Records Balto. City Hospitals ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease

DUE TO arteriosclerotic C.V. disease

(B) Intestinal obstruction

DUE TO Mesenteric thrombosis

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-11-, 1948, *to* 1-31-, 1949 *that I last saw the deceased alive on* 1-31-, 1949, *and that death occurred at* 3.45 P., *from the causes and on the date stated above.*

23A. SIGNATURE: P. D. Rogers M. D.

23B. ADDRESS: 4940 Eastern Ave.

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/3/49

24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 2 1949

REGISTRAR'S SIGNATURE: Dorothy Lee Williams, M.D.

25 FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

Vs 150

93D

Mbg / CERTIFICATE CORRECTED 2-25-49 ✓

G71176 BALTIMORE CITY HEALTH DEPARTMENT 420 / G71176

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Dean M. Gillespie

2. DATE OF DEATH: FEB 2 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Colorado
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Denver
D. STREET ADDRESS (If rural, give location): 632 Humboldt St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	5-3-84	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Engineer

10B. KIND OF BUSINESS OR INDUSTRY: Dean Gillespie Co.

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: W. D. Gillespie

14. MOTHER'S MAIDEN NAME: Isabel Black

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-27 1949, *to* 2-2 1949, *that I last saw the deceased alive on* 2-2 1949, *and that death occurred at* 2 30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: John G. Wilmer M. D. | 23B. ADDRESS: JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal | 24B. DATE: 2/2/49 | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State): Denver, Colorado

DATE RECEIVED BY LOCAL REGISTRAR: FEB 2 1949 | REGISTRAR'S SIGNATURE: [illegible] | 25. FUNERAL DIRECTOR ADDRESS: Wm. J. Tickner & Sons - Mount Royal Ave

VS 150

94a

G71177 BALTIMORE CITY HEALTH DEPARTMENT 903.5 G71177
BIRTH NO. CERTIFICATE OF DEATH E1820 Registered No.

1. NAME OF DECEASED (Type or Print) AUGUST KESTING
2. DATE OF DEATH January 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 901 South Fremont St. 2-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Single		71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore Md	

13. FATHER'S NAME Adolph Kesting
14. MOTHER'S MAIDEN NAME Christina ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Elsie A. H. Schneider	Carver Beach

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia.
DUE TO Fracture neck of femur.
(C) Arteriosclerosis.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☑ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street	900 block of South Fremont Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
12 31 48 7 p. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Slipped and fell to sidewalk

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George A. Merrill M.D.		Feb. 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/3/1949	Glen Haven	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 2 1949
REGISTRAR'S SIGNATURE Lester for Williams, M.D.
25. FUNERAL DIRECTOR Flynn & Fleming ADDRESS 1426 Light St.

VS 151

186a

G71178 ✓ X G71178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

151 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM PORTER MERRITT

2. DATE OF DEATH: Feb. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: Yrs. 30 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Va.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chincoteague
D. STREET ADDRESS (If rural, give location): 147 N. Main St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	7/13/83	65	6	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Merritt
14. MOTHER'S MAIDEN NAME: Levine Burch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO: 216-16-7090
17. INFORMANT: Records- US Marine Hospital, Balto, Md. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pericarditis	Unknown
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO	Gastric resection, postoperative (treatment for carcinoma of) stomach	6 days
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 3, 1949, *to* Feb. 2, 1949, *that I last saw the deceased alive on* Feb. 2, 1949, *and that death occurred at* 9:25 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson, Sr. Surgeon M. D. / Clinical Director
23B. ADDRESS: US Marine Hospital, Balto. Md.
23C. DATE SIGNED: 2/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/5/49
24C. NAME OF CEMETERY OR CREMATORY: RED MENS
24D. LOCATION (City, town, or county) (State): CHINCOTEAGUE VA.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 3 1949
REGISTRAR'S SIGNATURE: Beatrice Gordon Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook Inc ADDRESS: Balto. Md.

46 B

G71179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 420.1

Registered No. G71179

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2324 E. Oliver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore E-4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 E. Oliver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence E. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Ida B. Thomas
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 24, 1884

8. AGE: Years	Months	Days	If less than one day
64	6	9	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Loader Incubator
11. Industry or business Confection

FATHER
12. Name Jonathan Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca - ?
15. Birthplace Md.

16 (a) Informant Mrs Ida B. Thomas
(b) Address 2324 E Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-49 (month) (day) (year)
(c) Cemetery or crematory Greenfield
Location Sykesville, Md.

18 (a) Funeral director C. Harry Dew
(b) Address Sykesville, Md.

FEB 3 1949
(Date received by Registrar)

(Signature of Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1949, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1948 to Jan 1 1949 and that I last saw h[illegible] alive on Jan 1 1949.

Immediate cause of death [illegible] Duration 4 days

Due to Coronary thrombosis 3 wks

Due to [illegible] Arteriosclerosis over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 1513 N. Milton Ave Date signed 2 Feb 49

94a

VS 150

G71180

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.1 B27 G71180 Registered No.

1. NAME OF DECEASED (Type or Print): Joseph R. Akers

2. DATE OF DEATH: 2/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2115 Barclay St.
C. Length of stay in Baltimore. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2115 Barclay St. 12-4

5. SEX	6. COLOR OR RACE	7. ~~SINGLE, MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
M	W	Widowed	2-18-1892	56	11	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tile Setter	Building	Balto. Md.	U.S.A.

13. FATHER'S NAME: Joseph Akers

14. MOTHER'S MAIDEN NAME: Rose Vanes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Regina Stiffler ADDRESS: 317 E. 21st St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease.

~~DUE TO~~ DUE TO

(B) Chronic alcoholism (history)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George A. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-4-49	U. S. National	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 3 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

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G71181 ✓422.1 G71181

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): EMMA THERESA SMITH

2. DATE OF DEATH: 31 JANUARY-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTO., Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3419 ELMORA AVENUE

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3419 Elmora Ave. 8-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	MARRIED	Sept 5, 1863	85				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Germany	

13. FATHER'S NAME: Ernest Jones

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Mr. William Smith	3419 Elmora Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

15. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho-pneumonia — DUE TO

(B) Cardiac FAILURE — DUE TO

(C) Arteriosclerotic Cardiovascular disease

ANTECEDENT CAUSES

II — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 7 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 25 Jan, 1949, *to* 31 Jan, 1949, *that I last saw the deceased alive on* 31 Jan, 1949, *and that death occurred at* 7:20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Stanley B. Klyanowicz M.D.	1137 N. St. Paul St	31 Jan 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/3/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 3 1949	[illegible]	William Cook Inc.	1217 St. Paul St.

FEB 3° 1949

937

G71182

BALTIMORE CITY HEALTH DEPARTMENT 420.1 G71182

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SAMUEL TABACKMAN

2. DATE OF DEATH: 2-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4050 Annellen Road

c. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15 11
D. STREET ADDRESS (If rural, give location): 4050 Annellen Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	married		64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Romania	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph	Jessie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		212-07-9314 A	Leah Tabackman	4050 Annellen Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) coronary arterysclerosis with recurrent attacks of coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO

(B) — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1944 19__ *to* Feb 2 19 49, *that I last saw the deceased alive on* 1 30 49 19__, *and that death occurred at* 6:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Meeker Kirby MD M. D.	2320 Eutaw St	2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-3-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 3 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Place

FEB 3 1949

94a

G71183

420.1 G71183

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS [redacted]VARSOVSKY

2. DATE OF DEATH: 2/2/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale
C. Length of stay in Baltimore: 44 Yrs. [redacted] Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-5
D. STREET ADDRESS (If rural, give location): 2120 Wilkins Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months Days	If under 24 Hours: Hours Min.
Male	White	Widowed		79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Russia	

13. FATHER'S NAME: Lash

14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Louis Varsov	2120 Wilkins Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
ANTECEDENT CAUSES
(B) Arteriosclerosis
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 16, 1948, *to* Feb 2, 1949, *that I last saw the deceased alive on* 2/2, 1949, *and that death occurred at* 9:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jerome J. Blumberg M. D.	Levindale Home	2/2/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-3-49	United Hebrew	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 3 1949	Henrietta for Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

FEB 3 1949

94a

G71184
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

434.1 ✓ G71184
Registered No.

1. NAME OF DECEASED (Type or Print): MARGARET (FANTROY) JACKSON

2. DATE OF DEATH: February 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1128 Druid Hill Avenue 17-2

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 9, 1910
9. AGE (In years last birthday): 39 (djm) If under 1 Year: Months, Days; If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Galveston, Texas
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT ADDRESS: Samuel Fauntleroy, 1128 Druid Hill Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Edema
DUE TO
(B) Acute Congestive Heart Failure
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Emil L. Beyl M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 2-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 5, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Mt. Winder, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949 FEB 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles H. Alexander
ADDRESS: 1200 McCulloh St.

93E

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G71185 ✓422.1 G71185

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): George Richter

2. DATE OF DEATH: Jan. 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 254 S. Bouldin St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 68 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 254 S. Bouldin Street 26-10

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov. 1, 1876
9. AGE (In years last birthday): 72 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: 215-07-3572
17. INFORMANT: John Strausbaugh, 254 S. Bouldin St. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute myocardial failure & hypostatic congestion and pulmonary edema — Dec 29 1948

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 29 1948, *to* Jan 30, 1949, *that I last saw the deceased alive on* Jan 30, 1949, *and that death occurred at* 11:35 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: George S. Kelly M. D.
23B. ADDRESS: 732 S. Patterson Park Ave.
23C. DATE SIGNED: 1/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/3/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Taylor Ave., Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Courtenay for Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street

VS 159 FEB 3 1949

97

correct age is especially important. Physician: please write the cause of death clearly and accurately.

G71186 ✓ 161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71186

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stephen Smolek

2. DATE OF DEATH: Jan. 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1302 W. Lexington St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home of Our Lady

c. Length of stay in Baltimore: Yrs. 1907 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2524 Ashland Avenue 7-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	Sept. 12, 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	Bickford's	Czechoslovakia	U.S.

13. FATHER'S NAME: Joseph Smolek

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	213-01-3472	Mrs. Pauline Smolek	2524 Ashland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Larynx — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 22, 1949 *to* Jan 31, 1949 *that I last saw the deceased alive on* Jan 31, 1949, *and that death occurred at* 10:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Glassman M. D.	753 W. Fayette St	Feb 3 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/4/49	Holy Redeemer Cem.	4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR AND ADDRESS
FEB 3 1949 FEB 4 1949 FEB 5 1949	Timothy F. Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

47a

Correct age is especially important. Physician, please write the cause of death clearly and accurately.

G71187 #21 ✓ 464 G71187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71187

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lloyd L. Nay
2. DATE OF DEATH: FEB 2 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 8 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2227 Eutaw Place 13-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	10-20-07	41	3	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contact Op.	Davidson Chem. Corp.	W. Va.	

13. FATHER'S NAME: Alpheus Nay
14. MOTHER'S MAIDEN NAME: Maude Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 236-14-1794
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peptic Ulcer, Chronic
(B) Jejunal Pulmonary Embolism
DUE TO
(C) Phlebothrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Dec 28, 1948
19B. MAJOR FINDINGS OF OPERATION: See above
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-19-, 1948, *to* 2-2-, 1949, *that I last saw the deceased alive on* 2-2-, 1949, *and that death occurred at* 12:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: D. Kaplan M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: Feb 2 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/6/49	Pine Street Cemet	Gallipolis Ohio

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Huntington for Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Charles P Towell 2427 Edmondson Ave

US 150

117a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

AB-126446

G71188 B.C.49-0376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 476

Registered No. G71188

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby Girl Thomas-Twin-A

2. DATE OF DEATH: Jan. 28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 808 George St. 17-2

5. SEX: F
6. COLOR or RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan. 28-1949
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Virginia Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records- ADDRESS: Baltimore City Hospitals 4940 Eastern Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: Life
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [ ] NO [X]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan.28- , 1949 *to* Jan.28- , 1949 *that I last saw the deceased alive on* Jan.28- , 1949 *and that death occurred at* 6.57P *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: Feb.2, 1949
24C. NAME OF CEMETERY OR CREMATORY: P.C.H.
24D. LOCATION (City, town, or county) (State): 4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 3 1949
REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

FEB 3 1949

159

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AB-126447

✓ 776

G71189
BIRTH NO.

B.C. 49-03777

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71189
Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl- Thomas- Twin B

2. DATE OF DEATH: Jan. 28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Avenue

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 808 George St. 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Single	Jan.28-1949			1

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Virginia Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Baltimore City Hospitals Records- ADDRESS: 4940 Eastern Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Prematurity	Life
	DUE TO		
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO		
	(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 28- , 1949 *to* Jan. 28- , 1949 *that I last saw the deceased alive on* Jan. 28- 1949 *and that death occurred at* 6.57P *m., from the causes and on the date stated above.*

23A. SIGNATURE: P.L. Brosius M.D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: Feb. 2, 1949
24C. NAME OF CEMETERY OR CREMATORY: B.C.H.
24D. LOCATION (City, town, or county) (State): 4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 3 1949 FEB 4 1949
REGISTRAR'S SIGNATURE: Theodore [illegible] Registrar
25. FUNERAL DIRECTOR
ADDRESS

VS 150

6

159

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G71190 ✓ 422.1 G71190

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JULIA SCHALL

2. DATE OF DEATH: Jan. 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2920 Arlington Avenue
c. Length of stay in Baltimore: 33 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2920 Arlington Avenue 27-2

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 11, 1868
9. AGE (In years last birthday): 80 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Klinger
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mr. Paul Schall, Sr. ADDRESS: 2920 Arlington Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Years.
DUE TO
(B) Generalized arteriosclerosis — Years.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1949, *to* January 31, 1949, *that I last saw the deceased alive on* January 24, 1949, *and that death occurred at* 2:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry Sander M. D.
23B. ADDRESS: 30 E. Preston Street
23C. DATE SIGNED: 2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 2/3/49
24C. NAME OF CEMETERY OR CREMATORY: Western
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC. ADDRESS: BALTIMORE - 13, MARYLAND

VS 150
FEB 3 1949

93

Correct age is especially important. Physician: please write the exact number of years and not simply.

G71191 ✓163 G71191

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) JOHN BARBOUR (JOHN D. BARBOUR) — 2. DATE OF DEATH 2-2-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE

c. Length of stay in Baltimore 15 yrs Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) — A STATE MARYLAND — B COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE — D STREET ADDRESS (If rural, give location) 1219 Valley Street 10-1

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) If under 1 year: Months Days; If under 24 hours: Hours Min.
M	W	M	March 14, 1894	54

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Guard	Paul Jones Dis.	North Carolina	USA

13. FATHER'S NAME: William Barbour

14. MOTHER'S MAIDEN NAME: Scilina Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		237-22-8144	Mrs. Margaret Barbour	1219 Valley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Lung.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypertensive CVD.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-25- 1949 *to* 2-2-49, 19 , *that I last saw the deceased alive on* 2-2-, 1949 *and that death occurred at* 1:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank M. Lassiter, M. D.	Sinai Hospital, Baltimore	2-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/5/49	Holy Redeemer Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 3 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC.	

VS 150

FEB 3 1949

NORTH AVE. & BROADWAY 477

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71192

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 60 G71192

Registered No.

1. NAME OF DECEASED (Type or Print): Mrs Alice Elizabeth (Oates) Lynch

2. DATE OF DEATH: Feb. 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~Baltimore~~ Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 731 E. 22nd St. 9-7

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1885
9. AGE (In years last birthday): 64 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto., Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Francis P. Oates
14. MOTHER'S MAIDEN NAME: Marg. E. Hanlon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs Marg. Bowerman — ADDRESS 1708 Holbrook St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardio-vascular disease — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetis Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 1, 1949, *to* Feb. 2, 1949, *that I last saw the deceased alive on* Feb 1, 1949, *and that death occurred at* 1:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Phillip A. Peltz M.D. M. D.
23B. ADDRESS: 1400 N Caroline
23C. DATE SIGNED: Feb 2 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-5-49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): City

DATE RECEIVED BY LOCAL REGISTRAR: FEB 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wiedefeld & Son — ADDRESS: Greenmount & 22nd

VS. 150 FEB 3 1949

61

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71193 ✓ 422.1 G71193

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM A. RICE

2. DATE OF DEATH: January 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1045 N. Mount Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1045 N. Mount Street 16-3

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 1882
9. AGE (In years last birthday): 66 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer (Bus Boy)
10B. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Calvert Co., Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Rice
14. MOTHER'S MAIDEN NAME: Rebecca Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-14-5242
17. INFORMANT: Pauline Ireland ADDRESS: 1045 Mount Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (INTERVAL BETWEEN ONSET AND DEATH)

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteio-Sclerotic Cardiac
(B) Vascular Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Emil Beyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-3-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: FEB 3 1949
REGISTRAR'S SIGNATURE: Thomas for Williams, M.D.
25. FUNERAL DIRECTOR: V. A. Brooks ADDRESS: 1463 N. Carey St

93D

VS 151

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71194

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 422.1 G71194

Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES WEST

2. DATE OF DEATH: January 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: 40 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1118 N. Stricker Street 16-B

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	Colored	Married	May. 6. 1881	67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Hanover Va.	U. S. A.

13. FATHER'S NAME: Jessie West

14. MOTHER'S MAIDEN NAME: Isabell ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Bernice Meade ADDRESS: I413 N. centeral Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteio-sclerotic Cardio

DUE TO

(B) Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl L Boyle M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 1-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Bural

24B. DATE: Feb. 3. 1949

24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvery Cem.

24D. LOCATION (City, town, or county) (State): Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 3 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1000 Branyly Ave.

VS 151

93D

G71195 ✓ 420.1 G71195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ROSINA C. PASSANO
2. DATE OF DEATH: Feb. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5505 Jonquil Ave.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5505 Jonquil Ave. 2-1-49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
Female	White	Single	Aug. 30, 1868	80 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Reisterstown, Md.	

13. FATHER'S NAME: Joseph Passano
14. MOTHER'S MAIDEN NAME: Parthenia Crawford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	none	Mr. Joseph Passano	5505 Jonquil Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-29, 1949 *to* 2-1, 1949 *that I last saw the deceased alive on* 1-31, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. G. Dunn M. D.	Med. arts Bldg.	2-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/4/49	Greenmount Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 3 1949	[illegible]	WM. J. TICKNER & SONS	Balto., Md.

VS 150

94a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71196 ✓ 422.1 G71196

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MARK E. HEYDORN

2. DATE OF DEATH: Feb. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2312 Harlem Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2312 Harlem Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Jan. 6, 1875	74 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Customs Inspec.	U. S. Gov't.	Washington, D. C.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Mark Heydorn	Mary T. Fowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	none	Mrs. Manie Z. Heydorn	2312 Harlem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arterio Sclerosis.	several years
DUE TO (B)	Chronic Myocarditis.	several years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Age.	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jany. 5, 1949 *to* Feb. 2, 1949, *that I last saw the deceased alive on* Feb 1, 1949, *and that death occurred at* 4P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert C. Blake M. D.	Med. arts Bldg	2-3-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/5/49	Loudon Park Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 3 1949	Huntington Williams M.D.	WM. J. TICKNER & SONS	Baltimore, Md.

VS 150

937

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

422.2

G71197

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): SARAH LONG

2. DATE OF DEATH: Feb. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 7 N. Carrollton Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 7 N. Carrollton Ave.

18-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	Widow	Mar. 7, 1872	76 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	

13. FATHER'S NAME: Henry Vahle

14. MOTHER'S MAIDEN NAME: Mary Becker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		none	Mrs. Marie E. Fisher	415. Overbrook Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pneumonia	1 day.
DUE TO	Acute Bronchitis	
ANTECEDENT CAUSES (B)	Chronic Myocarditis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 2, 1947 *to* Feb 2, 1949, *that I last saw the deceased alive on* Feb 1, 1949, *and that death occurred at* 4:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Milton Sussman M. D.	1429 W Fayette St	Feb. 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/4/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 3 1949	Huntington Williams M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

937

correct age is especially important. Physician: please write the cause of death clearly and legibly.

ES-126517
G71198

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

260 G71198

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Julia Dilutis

2. DATE OF DEATH Feb. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospitals

c. Length of stay in Baltimore 17 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1010 E. Balto. St. 5-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Divorced	Mar. ?26-190?	42?	10 8	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Michael Mollica Moley Or Maley ?
14. MOTHER'S MAIDEN NAME Julia Florence Farina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
RECORDS-BALTO. CITY HOSPITALS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetic coma and acidosis ~~Diabetes Millitus~~

DUE TO

(B) Diabetes mellitus ~~Pulmotive~~ ~~Heart Disease~~

DUE TO

(C) ~~Duration ?~~ Rheumatic heart disease ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 Days over

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 1, 1949, *to* Feb. 2, 1949, *that I last saw the deceased alive on* Feb. 2, 1949, *and that death occurred at* 3:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE G. L. Rogers M. D.
23B. ADDRESS 4940 Eastern Ave.
23C. DATE SIGNED 2-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Feb. 5/49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State) Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR FEB 3 1949
REGISTRAR'S SIGNATURE ~~Municipality for Hillsville, Md~~
25. FUNERAL DIRECTOR John A. Miller
ADDRESS 2334 Jefferson St

VS 150

61

To insure correct age is especially important. Physician, please write the cause of death clearly and legibly.

G71199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

754-H

Registered No. G71199

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary D. Bryan

2. DATE OF DEATH: Feb. 2 - 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 407 N. Port St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 407 N. Port St. Balto. Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 6-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White		April 4-1933	15	9	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto. Md.	

13. FATHER'S NAME: Melvin C. Bryan

14. MOTHER'S MAIDEN NAME: Helen M. Stanek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Helen M. Bryan	407 N. Port St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: birth

DUE TO

(B) & Associated Congenital Cerbral Hemorrhage Disease — 8 t

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Chronic Respiratory Disease Complicated — 5 months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Acute Cardiac Failure — 24 hrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 2, 1949 *to* Feb 3, 1949 *that I last saw the deceased alive on* Feb 2 1949, *and that death occurred at* 1:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Israel Rosen M.D.	2432 Monument St.	2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 4/49	Holy Redeemer Cem.	Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 3 1949	Huntington Williams, M.D.	John R. Miller	2334 Jefferson St.

VS 150

157E

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71200 Roy ✓ x 146 G71200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Roy Cousins

2. DATE OF DEATH February 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dubois
D. STREET ADDRESS (If rural, give location) 407 Maury St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	10-29-94	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner		Pa.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Cousins	Caroline Franty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of nasopharynx — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO Squamous cell carcinoma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C) Prefrontal lobotomy for pain — 7 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/28/49	Prefrontal lobotomy done.	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 1-13, 1949, to 2-2, 1949, that I last saw the deceased alive on 2-2, 1949, and that death occurred at 10 P. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Medical Officer M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Feb. 3, 1949	Dubois	Penna.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 3 1949	Acting for Williams, M.D.	William J. Tickner & Sons.	North & Pa. Aves.

VS 150

45F

G71201 ✓443 G71201

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Martha Ella Morgan

2. DATE OF DEATH Feb. 1/49.

3. PLACE OF DEATH: A. Baltimore City, Maryland 312 S. Fulton Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Matyland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 312 S. Fulton Ave. 19-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Female	White	Married	Aug. 17, 1870	78	5	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H.W.		Baltimore, Md.	

13. FATHER'S NAME: William Thompson

14. MOTHER'S MAIDEN NAME: Martha Merson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No			Nellie Sarbacher, 312 S. Fulton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Hypertensive Cardiovascular Disease — 7 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 29, 1947, *to* Jan 31, 1949, *that I last saw the deceased alive on* Jan 31, 1949, *and that death occurred at* 2:30 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard Yaggy, M. D.	3101 W. Baltimore St.	2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 4/49.	New Cathedral, 4300 Old	Frederick Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 3 1949	Hunter for Williams, M.D.	Harry A. Leitz	4101 Edmondson Ave.

VS 4-50

937

Correct age is especially important. Physician please write the cause of death clearly and legibly.

G71202 420.1 G71202

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANDREW M. FRAZIER

2. DATE OF DEATH: Jan. 31, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 613 S. Clinton St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 613 S. Clinton St. 26-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Dec.19,1873	75	1	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Railroad Worker
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Frazier
14. MOTHER'S MAIDEN NAME: Margaret ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 717-07-8616
17. INFORMANT: Barbara W. Frazier; ADDRESS: 613 S.Clinton

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
ANTECEDENT CAUSES
(B) arteriosclerosis - generalized
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 11, 1938 *to* Jan. 31, 1949 *that I last saw the deceased alive on* Jan 30, 1949 *and that death occurred at* 9.50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis J. Kleiner M. D.
23B. ADDRESS: 2625 E. Monument St
23C. DATE SIGNED: 2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb.3,1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 3 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Charles S. Zeiler, ADDRESS: 901 S. Conkling St.

VS 150

94a

M M. 125327 G71203 ✓ 581.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No. G71203

1. NAME OF DECEASED (Type or Print) Joseph Waechter F. A

2. DATE OF DEATH Feb. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 437 Folcroft ST. Z 24 26 05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	W	Widowed	Nov. 16, 1888	60 yrs	2	16		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	BALTO. CITY WORKER	Maryland	

13. FATHER'S NAME ~~Deceased~~ KARL WAECHTER

14 MOTHER'S MAIDEN NAME ~~Deceased~~ ELIZABETH BRAUNSCHWEIGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
		217-26-7644	B.C.H. Records,	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arterio- Selerotic H. D.	2 mos.
DUE TO (B)	Pulmonary Ademia	2 hrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Laennecis Cirrhosis	2 mos -plu
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		Yes ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-13, 1948, *to* Feb. 2, 1949, *that I last saw the deceased alive on* Feb. 2, 1949, *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
C. S. Rogers M. D.	B. C. H. 4940 Eastern Ave.	Feb. 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
BURIAL	2-5-49.	SACRED HEART CEM.	GERMAN HILL RD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 3 1949	Beatrice Williams, M.D.	Charles L. Zeiler	901 S. Bonkling St.

VS 150

124a

Please write clearly and legibly. Physician, please write the cause of death clearly and correct age is especially important.

G71204 ✓ 422.1 G71204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George H. Rooney

2. DATE OF DEATH 2/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 138 Tappan St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 138 Tappan St, N. 26-44

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	7-4-1873	75	6	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Balto. Md.	

13. FATHER'S NAME Patrick Rooney

14. MOTHER'S MAIDEN NAME Margaret Rooney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Mildred Hayes ADDRESS 2420 Belmore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Broncho pneumonia	3 days
DUE TO (B)	arteriosclerotic C.V.D	5 yrs.
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 1, 1942 *to* 2/ , 1949 *that I last saw the deceased alive on* 1/29, 1949 *and that death occurred at* 5 30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE J. Karl Brannen M. D. | 23B. ADDRESS 1212 Patterson Park Ave | 23C. DATE SIGNED 2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-4-49	New Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 3 1949 | REGISTRAR'S SIGNATURE [illegible] Williams, M.D. | 25. FUNERAL DIRECTOR AND ADDRESS John C. Melly Inc. - 2435 E. Oliver St

VS 150

93D

Exact age is especially important. Physician: please write the cause of death clearly and legibly.

✓ X 720 443

G71205

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71205 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Minnie Lulu Householder

2. DATE OF DEATH: Feb 3 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 503 Enson St
c. Length of stay in Baltimore: 2 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W. Va.
B. COUNTY: Mineral
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Keyser
D STREET ADDRESS (If rural, give location): 30 Mineral St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W		June 9-1876	72	7 / 27	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife	—	Cumberland Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Swisher	Rebecca Mc McBride

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
	NO		Mrs. Tony Fazzella	503 Enson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Acute congestive failure	
DUE TO (B)	Hypertension Cardiovascular disease	
DUE TO (C)	Arthritis	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1948, *to* Feb. 3, 1949, *that I last saw the deceased alive on* Feb. 3, 1949, *and that death occurred at* 11:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Louis R. Moser M.D. M. D.	4335 Park Heights Ave	Feb 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town or county) (State)
	2/4/49	Queen Mount	Keyser W. Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Huntington Williams, M.D.	Henry W. Jenkins & Sons Co	905 York Rd

VS 150

93c

Please write clearly and correct age is especially important. Physician: please write the cause of death clearly and

G71206 ✓X 145 G71206

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): DRENNEN, ROBERT

2. DATE OF DEATH: FEB 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

c. Length of stay in Baltimore: 29 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: WASHINGTON
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): HAGERSTOWN
D. STREET ADDRESS (If rural, give location): 453 W ANTIETAM

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 1896
9. AGE (In years last birthday): 53
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tool Worker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W. Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS DRENNEN
14. MOTHER'S MAIDEN NAME: Margaret Welsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Lyda DRENNEN ADDRESS: 527 W FRANKLIN HAGERSTOWN

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) RECTAL HEMORRHAGE OF UNK. ORIGIN	36 HRS
DUE TO	(B) POSSIBLE DICOUMAROL POISONING	4 DAYS
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CARCINOMA, RT. TONSIL, Post-op.	1½ YRS

19A. DATE OF OPERATION: 1/20, 1/11 1949
19B. MAJOR FINDINGS OF OPERATION: CARCINOMA, RT. TONSIL
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NO
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* FEB 1, 1949, *to* FEB 3, 1949, *that I last saw the deceased alive on* FEB 3, 1949, *and that death occurred at* 6:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: David Auld M. D.
23B. ADDRESS: Univ. Hospital
23C. DATE SIGNED: Feb 3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/7/49
24C. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24D. LOCATION (City, town, or county): Hagerstown (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Lucretia Williams, M.D.
25. FUNERAL DIRECTOR: C N SUTER & SONS ADDRESS: HAGERSTOWN Md

VS 150

45F

AB-126393

G71207
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

002

G71207
Registered No.

1. NAME OF DECEASED (Type or Print): Edward Pruss

2. DATE OF DEATH: Feb. 1-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
4940 Eastern Avenue

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2116 Fleet Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Divorced	Oct. 6-1906	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Pennsylvania	U.S.

13. FATHER'S NAME: John Pruss

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT'S ADDRESS
		Baltimore City Hospitals Records-4940 Eastern Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pulmonary Tuberculosis, bilateral	1 month
DUE TO	far advanced-	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Arteriosclerotic Heart Disease, mild	1 month

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 1-27- , 19 49 to 2-1- , 19 49 *that I last saw the deceased alive on* 2-1- , 19 49 *and that death occurred at* 10.50 PM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. S. Rogers M. D.	Baltimore City Hospitals	2-3-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/5/49	Holy Rosary	Reedle Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Lexington Williams, M.D.	Hallowell Cole Inc	1219 Hollins St

VS 150

13C

G71208

BALTIMORE CITY HEALTH DEPARTMENT 4 20 1

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G71208

1. NAME OF DECEASED (Type or Print): Elizabeth F Lokarty

2. DATE OF DEATH: Feb 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — COUNTY: 2202 Callow Ave Balto Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): " "
D. STREET ADDRESS (If rural, give location): 2202 Callow Ave 13-0 v

5. SEX: F
6. COLOR OR RACE: W
7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: 10-31-878
9. AGE (In years last birthday): 70 — If Under 1 Year: Months 3, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborlady
10B. KIND OF BUSINESS OR INDUSTRY: Sewer
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Laurence Miller
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-03-2147
17. INFORMANT — ADDRESS: Chas. F. Lokarty 2202 Callow Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Insp & Inquest *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: William J Kelbach M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: Feb 3rd 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/6/49
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Hennington Williams, M.D.
25. FUNERAL DIRECTOR: Wilson & Son
ADDRESS: 1214 Eutaw St

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. If any item is unknown, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

94a

G71209 ✓ 420.0 G71209

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Bernard Armstrong

2. DATE OF DEATH: February 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2101 Cold Spring Lane

c. Length of stay in Baltimore: 49 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1305 Argonne Drive 9-0 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	widowed	Feb. 9, 1877	71 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	fireman	Delaware City Delaware	

13. FATHER'S NAME: Samuel Armstrong

14. MOTHER'S MAIDEN NAME: Annie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
no	none	Mrs. Vernon Hoffebert 1305 Argonne Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteriosclerotic Heart Disease.	?
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 15, 1948, *to* Feb 1, 1949, *that I last saw the deceased alive on* 1/31, 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Norman R Kleeman M. D.	303 Edmondson Ave	2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	Feb. 4, 1949	Baltimore Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 4 1949	Justine for Williams, M.D.	Krause Funeral Home 1216 S. Charles St.

VS 150

937

correct age is especially important. Physician: please write the cause of death clearly and fully.

G71210 Disposal

✓ X 762.5 G71210

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Mouzon

2. DATE OF DEATH: Feb. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Co.
D. STREET ADDRESS (If rural, give location): 1232 Forrest Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		1-31-49		,	16

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Sam Mouzon

14. MOTHER'S MAIDEN NAME: Elizabeth Winehold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxia

DUE TO

(B) Prematurity

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Eugene O. Goldstein M. D.	JOHNS HOPKINS HOSPITAL	2/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Hop Disposal	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Huntington for Williams, M.D.		

VS 150

159

G71211 68 358.

Hospital Deaths ✓ X 760.0 G71211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Baby Girl Gale

2. DATE OF DEATH Feb. 1, 1949

3. PLACE OF DEATH: A. Baltimore City Maryland Johns Hopkins Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Kent
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kennedyville
D. STREET ADDRESS (If rural, give location)

5. SEX female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 1-30-49 | 9. AGE (In years last birthday) | If Under 1 Year: Months Days 2 | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Jeff

14. MOTHER'S MAIDEN NAME Margaret Gale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) SUB DURAL HEMATOMA — INTERVAL BETWEEN ONSET AND DEATH: 36 Hours
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) APNEA AT BIRTH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-30-, 1949 *to* 2-1-, 1949 *that I last saw the deceased alive on* 2-1-, 1949 *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Alan C Mermann M. D. | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED 2-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY Rock Spring | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR FEB 4 - 1949 | REGISTRAR'S SIGNATURE Countersigned for Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS

VS 150

160a

Please write clearly and correct age is especially important. Physicians: please write the cause of death clearly and

G71212 B.C. 49-01898al Hospital Dept

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

776 G71212

Registered No. 184764

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Spence

2. DATE OF DEATH: February 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

C. Length of stay in Baltimore: 4 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 238 North Colvin Street

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: February 1, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 2 22

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Elester Spence
14. MOTHER'S MAIDEN NAME: Daisy Scott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Daisy Spence — ADDRESS: 238 North Colvin Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February 1, 1949 *to* February 1, 1949, *that I last saw the deceased alive on* February 1, 1949, *and that death occurred at* 10:10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Glen G. Rice M. D.
23B. ADDRESS: 601 North Broadway
23C. DATE SIGNED: 2-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hoy Dufaal
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS:

VS 150

159

PLEASE WRITE LEGIBLY. USE INK AND DO NOT ERASE. Every item of information should be answered correctly. Exact age is especially important. Physician: please write the cause of death clearly and legibly.

✓ 443

671213

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

671213

BIRTH NO. _____ Registered No. _____

1. NAME OF DECEASED (Type or Print) Dave Thompson

2. DATE OF DEATH January 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1618 W Lanvale St.
C. Length of stay in Baltimore 20 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1618 W Lanvale St. 16 03

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 6, 1889
9. AGE (In years last birthday) 59 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) –
10B. KIND OF BUSINESS OR INDUSTRY –
11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Rev. Thompson
14. MOTHER'S MAIDEN NAME unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Mrs. Elizabeth Thompson ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Heart-Disease — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertension — ?
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION none
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/6, 1948 *to* 1/31, 1949 *that I last saw the deceased alive on* 1/29, 1949, *and that death occurred at* 10:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE E. Wallis Sherrington M.D.
23B. ADDRESS 201 N Carey St.
23C. DATE SIGNED 2/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 2/4/49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary
24D. LOCATION (City, town, or county) (State) Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 4 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR George G. Kelson ADDRESS 1303 Pressman St

VS 150

93D

G71214 ✓ 422.1 443 G71214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELIZABETH B. BAKER

2. DATE OF DEATH: FEB. 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 610 SOMERSET RD.

C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 610 SOMERSET RD. 27-14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F.	W.	WIDOWED	OCT. 22, 1869	79	3	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BALTO. CO., MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM BAKER JR.

14. MOTHER'S MAIDEN NAME: PARTHENIA PASSANO

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MILDRED BAKER KELLEY ADDRESS 610 SOMERSET

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 mo

DUE TO

(B) Myocarditis — Gradual

DUE TO Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct., 1946 *to* Feb 2, 1949, *that I last saw the deceased alive on* Feb 1, 1949, *and that death occurred at* 9:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: D.A. Neady M. D.

23B. ADDRESS: 1403 Park Ave

23C. DATE SIGNED: 2-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2-5-49

24C. NAME OF CEMETERY OR CREMATORY: LOUDON PARK

24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949

REGISTRAR'S SIGNATURE: Countersigned for Williams, M.D.

25. FUNERAL DIRECTOR: H. W. JENKINS & SONS ADDRESS 4905 YORK RD.

VS 150

939

G71215 422.1 G71215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. CARROLLTON AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 16 01
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
77	1		hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Powell
15. Birthplace Md.

16 (a) Informant Samuel Johnson
(b) Address

17 (a) Burial (b) Date thereof 2-7-49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) FEB 4 1949 Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 3, 1949, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV. 15 1948. to FEB. 3, 1949. and that I last saw HIM alive on FEB 1, 1949.

Immediate cause of death	Duration
ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris, M.D.
M. D.
Address 1824 W. Franklin St Date signed 2-3-49

VS 150

935

G71216 ✓ 15D G71216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ALOYSIUS S. HOUSTON
2. DATE OF DEATH: 2-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPH's HOSPITAL
c. Length of stay in Baltimore: 8 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1940 PERLMAN PLACE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	8-13-96	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER	CONSTRUCTION	PENNA.	U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		PATIENT	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) MEDIASTINITIS — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) RUPTURED CANCER OF ESOPHAGUS
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
1-14-49 1-18-49	CANCER OF ESOPHAGUS	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-11 1949 *to* 2-3 1949 *that I last saw the deceased alive on* 2-3 1949, *and that death occurred at* 6:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Joseph Kreps M. D.	1400 N. Caroline St	2-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 7th 1949		Elyphant Penna.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	[illegible]	Leo D. Brooks	1201-03 N. Patterson Park Ave 462

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if correct age is especially important. Physician: please write the cause of death clearly and fully.

G71217 ✓ 420.1 G71217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Andrew Fisher

2. DATE OF DEATH: 2-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1604 Etting Str. 14

5. SEX: Male
6. COLOR OR RACE: Black
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3/8/82
9. AGE (In years last birthday): 46
If Under 1 Year: Months 10 Days 26
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Dry Prop Str.

11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Mary Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: self ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial congestion/failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

(B) Myocardial infarction — 5 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-24 19 49 *to* 2-2 19 49 *that I last saw the deceased alive on* 2-2 19 49 *and that death occurred at* 600 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Swan M.D. M. D.
23B. ADDRESS: Univ. Hosp.
23C. DATE SIGNED: 2-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-6-49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Fredericksburg, Va

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 19
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Charles R. Law ADDRESS: 802 Mad. ave.

VS 150

94a

G71218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581.0 G71218

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print) JOHN PETROVICH

2. DATE OF DEATH 2-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO GEN. HOSPITAL

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 111 Mc Mechen St 14 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	11/12/1908	40	2	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Building	Pa.	

13. FATHER'S NAME John Petrovich

14. MOTHER'S MAIDEN NAME Violet (Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		205-07-4762	Camille G. Petrovich	111 Mc Mechen St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) HEMORRHAGE
DUE TO
(B) PORTAL CIRRHOSIS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1/49, 19, to 2/2/49, that I last saw the deceased alive on 2/1/1949, and that death occurred at 1:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE, M.D.	23B. ADDRESS	23C. DATE SIGNED
Edward A. Gilchrist	West Balto Gen Hosp	2/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-5-49	Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Hunting for Williams M.D.	Wm Bok Inc.	1217 St. Paul St.

VS 150

124 B

G71219 171 G71219

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Mary Eliza Boyer

2. DATE OF DEATH February 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4702 Falls Road

c. Length of stay in Baltimore 50 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Maryland
D. STREET ADDRESS (If rural, give location) 4702 Falls Road 27 15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	Colored	Widowed	March 9,1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Amherst, Virginia	USA

13. FATHER'S NAME Hector Carter

14. MOTHER'S MAIDEN NAME Betty Miles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT James Jordan ADDRESS 6421 Deary St Pitts, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of cervix & right breast. DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: one year

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-28-1949 *to* 2-2, 1949 *that I last saw the deceased alive on* 1-30, 1949 *and that death occurred at* 2:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1612 Edmondson Ave	2-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 6,1949	Arbutus Memorial Park	Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	[signature] Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave

VS 150

48a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correct age is especially important. Physician: please write the cause of death clearly and fully.

Osl 2
G71220

✓ 420.0

G71220

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

269 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma Blackwell

2. DATE OF DEATH: FEB 2 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 213 N. Wolfe St 6 0 4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	?	1897	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas ?
14. MOTHER'S MAIDEN NAME: Martha ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Exogenous Obesity – Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-1- , 1949 to 2-2- , 1949, *that I last saw the deceased alive on* 2-2- , 1949, *and that death occurred at* 1 00 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sherman Wellington M. D.	JOHNS HOPKINS HOSPITAL	2/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/5/49	Mt. Calvary	A. A. County, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Hunting for Williams, M.D.	Joseph B. Lock, Jr.	130 N. Central Ave

VS 150

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physician: please write the cause of death clearly and legibly.

G71221 ✓ 585 G71221

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print): Peter Konrad

2. DATE OF DEATH: Feb. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4306 Springwood Ave. 26 01

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 6/21
9. AGE (In years last birthday): 64 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY: Tailoring
11. BIRTHPLACE (State or foreign country): Europe
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Mrs Grace Konrad

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: 4306 Springwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2hrs

DUE TO

(B) Coronary Sclerosis — ?

DUE TO

(C) Liver Abscess secondary to — 2 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Empyema of Gall Bladder

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 1/18, 1949, *to* 2/2, 1949, *that I last saw the deceased alive on* 2/2, 1949, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Alex O'Gilligan M. D.
23B. ADDRESS: South Baltimore General Hosp.
23C. DATE SIGNED: 2/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Bur
24B. DATE: Feb 5/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Timothy Joe Williams, M.D.
25. FUNERAL DIRECTOR: Welsh Funeral Home
ADDRESS: 2008 Orleans

VS 150

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G71222 ✓ 443 G71222

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print): Frank S. McGeeney

2. DATE OF DEATH: Feb. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 209 N. Kenwood Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 209 N. Kenwood Ave. 6 0 1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Oct. 12, 1875	73	3	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chief clerk	B & O R.R. Co.,	Baltimore, Md.	

13. FATHER'S NAME: Owen J. McGeeney

14. MOTHER'S MAIDEN NAME: Elizabeeth Yates

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.			Mrs. Beulah McGeeney	209 N. Kenwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: acute cardiac failure

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1 Feb., 1949, *to* 3 Feb, 1949, *that I last saw the deceased alive on* 3 Feb, 1949, *and that death occurred at* 4:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Stanley B. Kliszewicz M. D.	1127 N. St Paul St	3 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Bur	Feb 7 49	Oak Lawn	Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Municipal Registrar	Welsh Funeral Home	2008 Orleans

VS 150

931

G71223 ✓ 442 G71223

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Margaret Kellerman

2. DATE OF DEATH: Feb 1/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1821 Patt. Pk. Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE COUNTY 1821 Patterson Park Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8 C 7
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	widow	Mar 15 1880	68	11	13

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: August Mallon
14. MOTHER'S MAIDEN NAME: Dee ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Margaret Vetter ADDRESS 2627 Agnes St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypertensive cardio vascular	2-3 years
DUE TO	renal disease	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	General & cerebral arterio sclerosis	?
DUE TO (C)	—	—
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	—	—

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 12/15, 1948 *to* 2/1, 1949 *that I last saw the deceased alive on* 1/31, 1949 *and that death occurred at* 10 20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Harry Diesel M. D.
23B. ADDRESS 1126 Hanover St.
23C. DATE SIGNED 2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Feb 5
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Balto Cem
24D. LOCATION (City, town, or county) (State): Balto

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Wilbert Funeral Home ADDRESS 2005 Orleans

VS 150

131a

G71224

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 G71224
Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Robert E. Taylor

2. DATE OF DEATH: 2/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1565 Richland St. 13-43

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 5, 1906
9. AGE (In years last birthday): 42 — If under 1 Year: Months / Days; If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lancaster Co., Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jasker Taylor
14. MOTHER'S MAIDEN NAME: Mary Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sarah Taylor
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/4/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town or county): Balto. (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Theodora Lee Williams, Asst.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams
ADDRESS: 3221 Schroeder St.

VS 151

939

G71225 Hord. ✓ 260 G71225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Gertrude Baker Hord

2. DATE OF DEATH: 2-2-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Balt- Maryland B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimae
D. STREET ADDRESS (If rural, give location): 1510 West Fairmount Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Married	may 1, 1922	26				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Her home	None	Maryland	USA

13. FATHER'S NAME: Lewis Baker

14. MOTHER'S MAIDEN NAME: Dorothy Morrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Robert Hord	1510 W Fairmount

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetic coma — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1wk -

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 2-1 19 49 *to* 2-2 19 49 *that I last saw the deceased alive on* 2-2 19 49 *and that death occurred at* 1:40 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Brown MD M. D.	University Hosp	2-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-6-49	Mt. Calvary	R. R. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Huntington Williams, MD	Mrs Katie R. Williams	3224 Schroeder St

VS 150

61

G71226 ✓ 153 G71226

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print) SADIE R. GLENNON — GLENNON, SADIE R

2. DATE OF DEATH: 2-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1404 E. Oliver street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Widowed	7/4/1876	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home		Lebanon, Penna.	U.S.A.

13. FATHER'S NAME: Unknown Arnold

14. MOTHER'S MAIDEN NAME: Unknown -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
---	----	Miss Marie Glennon	1404 E. Oliver St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of Transverse Colon	
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Arteriosclerotic H.D.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2-1-49	Ca of Transverse Colon	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-24 19 49 *to* 2-2-49, 19 , *that I last saw the deceased alive on* 2-2, 19 49 *and that death occurred at* 10 40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard Kolb, M. D.	Sinai Hosp	2-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	FEB. 5-1949	Parkwood Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Huntington Williams, M.D.	Chas. S. Evans & Son Inc.	118 W. Mt. Royal Ave

VS 150

76E

G71227 ✓ 331 G71227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Clara Greason

2. DATE OF DEATH: Feb. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for the aged Poor Little Sisters of the Poor
c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St 10 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	W.	Aug. 3, 1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Hause
14. MOTHER'S MAIDEN NAME: Anne Farber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Sister Ignatius ADDRESS: 1200 Valley St Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	5 days
DUE TO (B)	Arterio-Sclerosis	5 yrs
DUE TO (C)		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 20, 1949, *to* Feb 2, 1949, *that I last saw the deceased alive on* Feb 2, 1949, *and that death occurred at* 2:15 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. Gill Hall M. D.
23B. ADDRESS: 1631 E. North ave
23C. DATE SIGNED: 2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: Feb 5 1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Rita Wiedefeld ADDRESS: 900 E Biddle St

VS 150

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G71228 ✓ 443 G71228

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): MIRIAM MICHEL.

2. DATE OF DEATH: 2/3/49.

3. PLACE OF DEATH: A. Baltimore City, Maryland — 3604 Mohawk Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Anderson Nursing Home.
c. Length of stay in Baltimore: 60 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2517 Brookfield. Ave. 13-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Single	5/10/1876.	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Office Worker	New York	U.S.A.

13. FATHER'S NAME: Gustave Michel

14. MOTHER'S MAIDEN NAME: Clara Strouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-28-1607.

17. INFORMANT: Mr. Gilbert Michel. ADDRESS: 2517 Brookfield Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral hemorrhage	1 month
DUE TO (B)	Celebral arteriosclerosis	?
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Hypertensive cardiovascular disease	?
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Bronchopneumonia	3 weeks

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 17, 1948 *to* Feb. 3, 1949 *that I last saw the deceased alive on* Feb. 3, 1949, *and that death occurred at* 3 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert N. Gundersheimer Jr. M. D.	Riviera Apts.	2/3/1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/4/1949.	Oheb Shalom Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Huntington Williams, M.D.	Harris Levine & Son	1902 Eutaw Place.

VS 150

6

92D

G71229 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422-1 G71229 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. correct age is especially important.

1. NAME OF DECEASED (Type or Print): Joseph Sterpakes
2. DATE OF DEATH: 2-3-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General DOA
C. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 419 Ostend St. 2 1 01
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Not know
9. AGE (In years last birthday): 56 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-09-1829A
17. INFORMANT — ADDRESS: Mr. Vincent Framsman, 830 Mangold St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/4/49
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart of Mary
24D. LOCATION (City, town, or county) (State): German Hill Road

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: SACRED Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: John A. Grebliauckas, Jr. 423 S. Paca St. 93

VS 151

G71230 ✓ 156.1 G71230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): BERTHA WELLS

2. DATE OF DEATH: Feb. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Beths Gate
D. STREET ADDRESS (If rural, give location): (illegible)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	married	June 10 1902	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	Home	?	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Chambers	Mamie ? Chambers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the liver
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 19__ *to* Feb. 3, 19 49, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 11 25 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sherwood Mellinkoff M. D.	JOHNS HOPKINS HOSPITAL	2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 6 1949	Bowlers	Beth Gate A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 4 1949	Hunting for Williams, M.D.	J. B. Johnson Annapolis, Md.

VS 150

46 F

G71231 ✓490 G71231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Phillip Brown

2. DATE OF DEATH 2-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland B. (If not in hospital or institution, give street address or location) 1031-N. Mount Street

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY City. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-03 D. STREET ADDRESS (If rural, give location) 1031 - N. Mount St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M.	Col.	Single	2-1-49		4			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Howard Brown 14. MOTHER'S MAIDEN NAME Bertha Brafton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Howard Brown ADDRESS 1031-N. Mount St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia (Bilateral) — INTERVAL BETWEEN ONSET AND DEATH: 4

DUE TO

(B) Common Cold. — 2

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Cardiac failure — Terminal

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-31, 1949 *to* 2-3, 1949 *that I last saw the deceased alive on* 2-3, 1949, *and that death occurred at* 3:00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE Thomas Sellers M. D. 23B. ADDRESS 1543 Penna. Ave. 23C. DATE SIGNED 2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 2/5/49 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary 24D. LOCATION (City, town, or county) (State) Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 4 1949 REGISTRAR'S SIGNATURE Hunter for Williams, M.D. 25. FUNERAL DIRECTOR ADDRESS Metropolitan Funeral Home 927-N. Mount St. 108

VS 150

G71232 ✓ 480 G71232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct. Age is especially important. Physician please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Ethel Williams

2. DATE OF DEATH: Feb. 3 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 117 W. Perry St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none
C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 117 W. Perry St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md
D. STREET ADDRESS (If rural, give location) 117 W. Perry St 2-2-01

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	1906	42 yrs	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at Home	none	Va.	—

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no		Percy Elkins	117 W. Perry

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1/14/49

DUE TO

(B) Influenza

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	none	none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Jan. 4 1949 to Feb 3, 1949, that I last saw the deceased alive on Feb 3, 1949 and that death occurred at 4.50 a.m. from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Lincoln Shelton M. D.	928 S. Chapel St	2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-6-49	Mt Calvary	A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Hunting for Williams, M.D.	James A Hayes	142 W Pratt

VS 150

33a

G71233 — 490 — G71233

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print): CLARA DOWNEY

2. DATE OF DEATH: February 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hoppital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 323 McMachen Street — 14-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	colored	Widow	Aug. 27, 1920	28	5	4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	—	Northumberland Co. Va.	U.S.A.

13. FATHER'S NAME: Spencer Johnson
14. MOTHER'S MAIDEN NAME: Mary Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Emily Smith — ADDRESS: 323 McMachen St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypostatic P.N. Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Royer, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Feb. 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 5, 1949
24C. NAME OF CEMETERY OR CREMATORY: Family Lot
24D. LOCATION (City, town, or county) (State): Northumberland Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Williams, M.D.
25. FUNERAL DIRECTOR: Mr. George H. Holland — ADDRESS: Union Mill Rd.

VS 151

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104

G71234 ✓606 G71234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and correct age is especially important.

1. NAME OF DECEASED (Type or Print): FRANK L. SCHEPLER

2. DATE OF DEATH: Feb. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 618 W. 40th St.
c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 618 W. 40th St.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: May 26, 1875
9. AGE (In years last birthday): 73 yrs. (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ex.Gn,Freight Claim Dept
10B. KIND OF BUSINESS OR INDUSTRY: B & O R R
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Frank Schepler
14. MOTHER'S MAIDEN NAME: Elizabeth Foss
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Clara M. Schepler
ADDRESS: 618 W. 40th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks +

DUE TO (B) Cardio. vascular renal disease with Multiple diverticulae in bladder. urinary infection — 5 yrs +

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1945
19B. MAJOR FINDINGS OF OPERATION: Su with ? Intestinal cause of death
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* Feb 3, 1949, *that I last saw the deceased alive on* Feb 2, 1949, *and that death occurred at* 1.74 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: E K Hayward M. D.
23B. ADDRESS: 13 E Eager St Balto.
23C. DATE SIGNED: 2/4-'49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/7/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Tenney for Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

FORM 150

131a

G71235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1 447

Registered No. G71235

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) BERTHA A. LITCHFIELD

2. DATE OF DEATH Feb. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2508 Druid Park Drive
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2508 Druid Park Drive 15 17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
female,	white	married	Feb. 9, 1885	63 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Fowble	Lydia ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no	Mr. Crafton Litchfield	2508 Druid Park Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Essential hypertension — 5 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 1936 *to* 2/3, 1949, *that I last saw the deceased alive on* 2/2, 1949, *and that death occurred at* 9:05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bruce Laughlin M. D.	400 N. Payson St.	2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/5/49	St. Paul Cem.	Upperco, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Kenneth Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

94a

✓ 450.0

G71236
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71236

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print) Robert T. Stevens

2. DATE OF DEATH 2/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospt. Green & Lombard St

c. Length of stay in Baltimore 55 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5117 Greenwich Ave. 28 C 4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W		June 18, 1874	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Chief Clerk	B. & O.	Talbot Co., Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Josiah Stevens	Sarah Mullikin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mrs. Dorothy Marburger	Apt. B-1 Greenwich Garden

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism — DUE TO

(B) Hemorrhoidectomy — DUE TO

(C) arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/14/49, 19__, *to* 2/2/49, 19__, *that I last saw the deceased alive on* 2/2/49, 19__, *and that death occurred at* 11 05 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward B. Hall M. D.	University Hosp.	2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/7/49	Loudon Park Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Registrar for Baltimore, Md.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

97

G71237

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

154 G71237

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Age, if not known exactly, should be correctly approximated. Date of death should be written clearly and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): HARRY CORNELIUS RIALE

2. DATE OF DEATH: 2-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSP 33rd & CALVERT
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 15-38
D. STREET ADDRESS (If rural, give location): 2705 ELSINORE AVE

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: Aug. 8, 1874
9. AGE (In years last birthday): 74
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Live stock dealer
10B. KIND OF BUSINESS OR INDUSTRY: LIVE STOCK
11. BIRTHPLACE (State or foreign country): Cecil Co. MARYLAND
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: MR. THOMAS RIALE
14. MOTHER'S MAIDEN NAME: CARRIE E ALGARD
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): ?
16. SOCIAL SECURITY NO: ?
17. INFORMANT: Mr. William Towner
ADDRESS: 4019 Woodhaven Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA Sigmoid — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) PERITONITIS — 4 days
DUE TO
(C) FECAL FISTULA - — 4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Remix

19A. DATE OF OPERATION: 1-24-49
19B. MAJOR FINDINGS OF OPERATION: CARCINOMA SIGMOID & LOCAL METASTASES
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): 0
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): 0
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 0
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 0 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: 0

22. *I hereby certify that I attended the deceased from* 1-19, 1949, *to* 2-3, 1949, *that I last saw the deceased alive on* 2-3, 1949, *and that death occurred at* 9:50A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thos. A. Tucker, M.D. M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/5/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Baltimore County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Cunningham for Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Baltimore Md.

VS 150

469

Medical Examiner Case 420.1

671238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

671238

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) John Henry Owens

2. DATE OF DEATH Feb 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S. Public Health Service U.S. Custom House
C. Length of stay in Baltimore 12 hrs Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institutional resident, before admission)
A. STATE South Carolina
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gaffney
D. STREET ADDRESS (If rural, give location) Sycamore St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	D	Dec 24, 1902	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant Seaman	Shipping	Gaffney South Carolina	U.S.

13. FATHER'S NAME Ben Owens

14. MOTHER'S MAIDEN NAME Martha Pruitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Lonnie H. Owens ADDRESS 733 E. Broad St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) CERTIFIED John R. Davis MD per A.A. Merrill M. D.

CHIEF OR ASST. MEDICAL EXAMINER.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from — , 19— , to — , 19— , that I last saw the deceased alive on — , 19— , and that death occurred at 1:50 P.M., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Roland Carroll M. D.	U.S. Custom House	Feb 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	2/4/49	Graytownsele	Gaffney, S.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Huntington Williams, M.D.	Wm. J. Tichenor & Sons	Baltimore

VS 150

94a

G71239
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

Registered No. G71239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and correct age is especially important.

1. NAME OF DECEASED (Type or Print) CHARLES H. WHITAKER
2. DATE OF DEATH 2-4-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.
C. Length of stay in Baltimore — Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Towson
D STREET ADDRESS (If rural, give location) 506 HIGHLAND Ave
5. SEX M
6. COLOR OR RACE W
7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) Married
8. DATE OF BIRTH Aug. 26, 1864
9. AGE (In years last birthday) 84 — If Under 1 Year: Months 3 Days 18 — If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
10B. KIND OF BUSINESS OR INDUSTRY CARPENTER
11. BIRTHPLACE (State or foreign country) Govanstown, Ba. Co. Md.
12. CITIZEN OF WHAT COUNTRY? —
13. FATHER'S NAME Henry Whitaker
14. MOTHER'S MAIDEN NAME Martha Duncan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service) No —
16. SOCIAL SECURITY NO None
17. INFORMANT Hospital Records — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion
DUE TO arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. bladder Tumor (Malignant)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-2, 1949, *to* 2-4, 1949, *that I last saw the deceased alive on* 2-4, 1949 *and that death occurred at* 7:44 m., *from the causes and on the date stated above.*

23A. SIGNATURE Nikolas Mallis M.D. — 23B. ADDRESS University Hosp. — 23C. DATE SIGNED 2-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE Feb. 7, 1949 — 24C. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem. — 24D. LOCATION (City, town, or county) Towson, Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR FEB 4 1949 — REGISTRAR'S SIGNATURE Hunting for Williams, M.D. — 25. FUNERAL DIRECTOR John Bernard Sons — ADDRESS Towson, Md.

VS 150

52B

671240 ✓ 762.5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 671240

BIRTH NO. B.C.-49-02004

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print): DAVID KULLMAN

2. DATE OF DEATH: 4 Feb 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital Balto 2 Maryland
c. Length of stay in Baltimore: 4 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 610 N Ellwood Balto 5 2-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	single	Jan 31, 1949			4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): New born
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Walter Kullman
14. MOTHER'S MAIDEN NAME: Anna Dudek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records, Mercy, Balto 2 Md ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Atalectasis	12 hrs
DUE TO (B)	Prematurity	4 days
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 31 Jan, 1949, to 4 Feb, 1949, that I last saw the deceased alive on 4 Feb, 1949, and that death occurred at 6:25A m., from the causes and on the date stated above.

23A. SIGNATURE: A. M. Bacon Jr M. D.
23B. ADDRESS: Mercy Hosp Balto 2 Md
23C. DATE SIGNED: 4 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 2/4/49
24C. NAME OF CEMETERY OR CREMATORY: St Stanislaus
24D. LOCATION (City, town, or county) (State): Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Function for Williams, M.D.
25. FUNERAL DIRECTOR: George A. Weber. ADDRESS: 705 S. Conkling 159

FEB VS 150

G71241 ✓ 260 49-1 G71241

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE WITH UNFADING INK. Every item of information must be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print) LAURA V. SALISBURY
2. DATE OF DEATH Feb 3 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1222 W. Pratt St
C. Length of stay in Baltimore 37 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1222 W. Pratt St 18 03

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov 24 1874
9. AGE (In years last birthday) 74
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Kent County Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel E. Cannan
14. MOTHER'S MAIDEN NAME Annie Higgins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ?
17. INFORMANT Edward R. Salisbury ADDRESS 1222 W. Pratt St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1
DUE TO
(B) arteriosclerosis — —
DUE TO
(C) diabetes mellitus — 11 mos.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* March 1948 *to* Feb. 3, 1949, *that I last saw the deceased alive on* 2-2, 1949, *and that death occurred at* 3.05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE O. L. Schreiber M. D.
23B. ADDRESS 1-4 S. Fulton Ave
23C. DATE SIGNED 2-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Feb 6-1949
24C. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem
24D. LOCATION (City, town, or county) (State) Rock Hall Kent Co Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 4 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR Roff & B. M. Walton ADDRESS Preston & Stockley Sts

VS 150

61

G71242 ✓ 422.1 G71242

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Joseph Arrington

2. DATE OF DEATH: 2/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 613 E. Baltimore St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 613 E. Baltimore St. 4-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Single		65 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?		U	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
World War I			

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George L. Merrill M.D.		2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2-4-49	Baltimore National	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Tuttington Williams, M.D.	Ellsworth Armacost	3911 Liberty Heights Ave 93

VS 151

G71243
JL - 126520

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71243
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charlene Apson	2. DATE OF DEATH Feb. 1, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. c. Length of stay in Baltimore 15 min. (Yrs. Mos. Days)	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 405 Finch Ct.
5. SEX F	6. COLOR OR RACE C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 26, 1948
9. AGE (In years last birthday) 4 Mo. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.	12 CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Laverne Apson	14. MOTHER'S MAIDEN NAME Lizzie Graham
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO
17 INFORMANT B. C. H. Records, 4940 Eastern Ave.	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

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INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 1, 1949 *to* Feb. 1, 1949, *that I last saw the deceased alive on* Feb. 1, 1949, *and that death occurred at* 7.40A *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS Balto. C. Hosp. 4940 Eastern Av.	23C. DATE SIGNED Feb. 1, 49
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/4/49	24C. NAME OF CEMETERY OR CREMATORY MtCalvary
24D. LOCATION (City, town, township) (State) Baltimore Md		
DATE RECEIVED BY LOCAL REGISTRAR FEB 4 1949	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR A Halstead
ADDRESS 908 Dundalk Ave		

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

Dr. L. B. Stevens
3400 Erdman Avenue

422.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71244

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and correct age is especially important.

1. NAME OF DECEASED (Type or Print)	Robert Michael Mc Ginn, Sr.
2. DATE OF DEATH	Feb. 1, 1949
3. PLACE OF DEATH: A.	Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	4206 Ari,ona Avenue
c. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	3013 Edgewood Avenue
5. SEX	male
6. COLOR OR RACE	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	widowed
8. DATE OF BIRTH	Mar. 20, 1865
9. AGE (In years last birthday) / If Under 1 Year Months / Days / If Under 24 Hours Hours / Min.	83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Retired
10B. KIND OF BUSINESS OR INDUSTRY	Bricklayer
11. BIRTHPLACE (State or foreign country)	Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Patrick Mc Ginn
14. MOTHER'S MAIDEN NAME	Catherine Mc Ginn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS	Miss Dorothy Horne, 3013 Edgewood Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular disease — Senility

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10, 1949, *to* Feb. 1, 1949, *that I last saw the deceased alive on* Jan 28, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	L B Stevens M. D.	
23B. ADDRESS	3400 Erdman Ave	
23C. DATE SIGNED	2/2/49	
24A. BURIAL, CREMATION, REMOVAL (Specify)	Burial	
24B. DATE	2-5-49	
24C. NAME OF CEMETERY OR CREMATORY	New Cathedral Cem.	
24D. LOCATION (City, town, or county) (State)	Baltimore, Maryland	
DATE RECEIVED BY LOCAL REGISTRAR	FEB 4 1949	
REGISTRAR'S SIGNATURE	Timothy Joe Williams, M.D.	
25. FUNERAL DIRECTOR ADDRESS	Leonard J. Ruck, 5305 Harford Road.	

VS 150

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G71245 416 G71245

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. Clifford John Rock (CR)

1. NAME OF DECEASED (Type or Print): John Clifford Rock

2. DATE OF DEATH: Feb. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secour
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2904 Bauernwood Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	June 30 1918	30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Leader
10B. KIND OF BUSINESS OR INDUSTRY: Glen L. Martin
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John J. Rock
14. MOTHER'S MAIDEN NAME: Stella C. Peters
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Madelaine Lock ADDRESS: 2904 Bauernwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral embolism
DUE TO
(B) Rheumatic Heart Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Congestive Heart failure

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 31, 1949 *to* Feb. 4, 1949 *that I last saw the deceased alive on* Feb. 3, 1949, *and that death occurred at* 7:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: D. Shohler M. D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/8/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: L. J. Keck ADDRESS: 5305 Harford Rds

VS 150

95K

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71246 ✓ 143

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71246

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. Give age in years, months, days, hours or minutes, whichever is important.

1. NAME OF DECEASED (Type or Print): JAMES AnDrew BAMBLING

2. DATE OF DEATH: February 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns HopKins Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1341 Crofton Road 27-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	Jan 12-1897	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. Production
10B. KIND OF BUSINESS OR INDUSTRY: Md Drydock
11. BIRTHPLACE (State or foreign country): Penn.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Bambling
14. MOTHER'S MAIDEN NAME: ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Marie Bambling ADDRESS: 1341 Crofton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage
DUE TO
(B) Hypertensive cardiovascular disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Chester J. Lubinski, M.D. per: M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED 2-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE 2/5/49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Park
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: L. J. Luck ADDRESS: 5305 Hanford Rd

VS 151

937

G71247 ✓177 G71247

Dr Edmonds
2746 Alameda

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): John W. Haase

2. DATE OF DEATH: Feb. 3. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4139 Marx Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4139 Marx Avenue 27-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
male	white	married	Apr. 21, 1869	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Cabinet, Maker	Germany	

13. FATHER'S NAME: John Haase

14. MOTHER'S MAIDEN NAME: Martha ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Mrs. Theresa Haase, 4139 Marx Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Intestines — INTERVAL BETWEEN ONSET AND DEATH: July - 1947

DUE TO

(B) Carcinoma Prostate — 1931

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 1947	Carcinoma colon secondary to Prostate	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1927 *to* 3-Feb, 1949 *that I last saw the deceased alive on* 3-Feb, 1949 *and that death occurred at* 11:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas O. Edmonds M. D.	2746 The Alameda	3-Feb-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2- -49	Parkwood Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 4 1949	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

51B

G71248e

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 420.1 G71248 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Samuel Wilson Church

2. DATE OF DEATH: Feb. 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4612 Mainfield Avenue

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4612 Mainfield Avenue 27-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	June 30, 1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nelson S. Church

14. MOTHER'S MAIDEN NAME: Laura V. Arthur

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Eliz. J. Church, 4612 Mainfield ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Acute Cardiac Failure	1½ days
DUE TO		
(B)	Coronary Thrombosis.	4 days
DUE TO		
(C)	Coronary Artery disease	Few years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 30, 1949, *to* Feb. 2, 1949, *that I last saw the deceased alive on* Feb 2, 1949, *and that death occurred at* 8 15 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: James E. White M. D.

23B. ADDRESS: 5214 Harford Rd.

23C. DATE SIGNED: 3 Feb 49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-5-49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949

REGISTRAR'S SIGNATURE: Hunting for Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

94a

G71249

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

421.4 G71249
Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print): Sauel T. Smith

2. DATE OF DEATH: Feb. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 632 N. Gilmor St,
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 632 N. Gilmor St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored	Widower	Oct. 1, 1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Cook	Baltimore, Md.	U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. C. Violet Pindle ADDRESS 632 N. Gilmor St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Val. H.D.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10, 1949 *to* Feb. 3, 1949, *that I last saw the deceased alive on* Feb 2, 1949, *and that death occurred at* 8:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter D. Layton M.D.	1522 Harlem Ave	2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-7-49	Mt. Auburn Cem	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Huntington Williams, M.D.	Jesse W. Ridden	436 W. Biddle St

VS 150

92D

G71250 ✓ X420.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. · Registered No. G71250

1. NAME OF DECEASED (Type or Print): Lewald, Dr James

2. DATE OF DEATH: 2-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: 6 days. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Anne Arundel
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Near Laurel
D. STREET ADDRESS (If rural, give location): Camp Meade Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W.	Married	July 29, 188	60	10 / 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Physician	Retired Formerly Training School	Pennsylvania, Ohio	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Oscar Lewald	Jennie Salomon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	World War I		Mrs Alice H Lewald	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary Embolism	
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Coronary Thrombosis	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-28, 1949 *to* 2-3, 1949 *that I last saw the deceased alive on* 2-3, 1949 *and that death occurred at* 7 40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Julia R Mansberger M. D.	Univ. Hosp. Balt	2-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	Feb 5, 1949	Bost Funeral	District Line, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Estelle for Williams, M.D.	W. Webb Donaldson	

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

94a

G71251 ✓170 G71251

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Margaret M. Sorrentino

2. DATE OF DEATH: Feb. 2 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2303 E. Biddle St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D STREET ADDRESS (If rural, give location): 2303 E. Biddle St. 8 c 4

5. SEX: Female
6. COLOR OR RACE: White
7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Febb. 13 1892
9 AGE (In years last birthday): 56 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.: 11 22
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Cefalu' Palermo Italy
12 CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Salvatore Maggio
14 MOTHER'S MAIDEN NAME: Giovannina ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 216-10-7360
17. INFORMANT: William Sorrentino — ADDRESS: 2303 E. Biddle St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Bronchial Pneumonia	2 days
DUE TO		
(B)	Carcinoma of Spine	6 mos
DUE TO		
(C)	Carcinoma of breast	2yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 14 Dec, 1948, *to* 2 Feb, 1949, *that I last saw the deceased alive on* 1 Feb, 1949, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.: Xavier Scarnato
23B ADDRESS: 1513 N. Milton Ave
23C DATE SIGNED: 2 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Febb. 5 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
24D LOCATION (City, town, or county) (State): Old Frederick Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: Frank Della Rocca
ADDRESS: 322 S. High St.

VS 150

50

✓ 142

G71252

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71252

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Maria Blake Or. Mariah Blake

2. DATE OF DEATH: Feb.3.1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 924 N. Eden St.
c. Length of stay in Baltimore: 26 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 924 N. Eden St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col.	Widow	July IC. 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Accomac Co.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jessie White
14. MOTHER'S MAIDEN NAME: Harriett White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ethel Wainwright ADDRESS: 924 N.Eden St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cardio-Renal Vascular Lesion	1 yr.
DUE TO (B)	Utero-sclerosis	1 yr.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1.15 , 1949 *to* 2.3. , 1949 *that I last saw the deceased alive on* 2.3. , 1949 *and that death occurred at* 6.50 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Irene LeRoy Lewis, M. D.
23B. ADDRESS: 1420 E. Chase St.
23C. DATE SIGNED: 2.4.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 6. 1949
24C. NAME OF CEMETERY OR CREMATORY: Accomac Cem.
24D. LOCATION (City, town, or county) (State): Accomac Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Beatrice Fox Williams, M.D.
25. FUNERAL DIRECTOR: Elroy C. Wilson ADDRESS: 1000 Brantly Ave

VS 150

1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

G71258 Reg ✓ 490 G71253

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Clarence Oliver Carter

2. DATE OF DEATH Feb. I. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 903 W. Saratoga St. Apt. 2

C. Length of stay in Baltimore 12 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN Balto. (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) 903 W. Saratoga St. Apt. 2 16 61

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Col.	Married	March I. 1918	30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffuer	Produce Pro	Anderson Sc. Anderson	U.S.A.

13. FATHER'S NAME Johny Carter

14. MOTHER'S MAIDEN NAME Annie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Janie Carter 903 W. Saratoga St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 1 19 49 *to* Feb 1 19 49 *that I last saw the deceased alive on* Feb 1 19 49 *and that death occurred at* 7:35 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C. DATE SIGNED
E. William Frey M. D.	1728 Penna Ave.	2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Feb. 4. 1949	Anderson Cem.	Anderson Sc.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 4 1949	Huntington Williams, M.D.	Elroy C. Wilson 1000 Brantly Ave.

VS 150

108

G71254 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

334 G71254 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and correct age is especially important.

1. NAME OF DECEASED (Type or Print): Annie Styles
2. DATE OF DEATH: Jan. 30. 1949
3. PLACE OF DEATH: a. Baltimore City, Maryland 628 N. Caroline St.
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: All Life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
d. STREET ADDRESS (If rural, give location): 628 N. CarolineSt
5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: March 3. 1883
9. AGE (In years last birthday): 65 65 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Styles
14. MOTHER'S MAIDEN NAME: Francis Chase
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Sarah Pinder ADDRESS: 1933 Penn. Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Apoplexy and Paralysis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/11 40 *to* 1/31 49, *that I last saw the deceased alive on* 1/30 19 48, *and that death occurred at* 7:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE Ben Rhatty M. D.
23b. ADDRESS 2179 Druid Hill Ave
23c. DATE SIGNED 2/2-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Feb. 3. 1949
24c. NAME OF CEMETERY OR CREMATORY: Mt. calvery Cem.
24d. LOCATION (City, town, or county) (State): Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1000 Brantly Ave.

VS 150

83a

G71255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.1 G71255

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Alice Gertrude Spencer

2. DATE OF DEATH: Feb. 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE — B. COUNTY

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ventnor Lodge-602 S Chapel Gate Ln.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 1 yr (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 602 Chapelgate Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed	About 73			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		South Carolina	

13. FATHER'S NAME: Harry McCusker

14. MOTHER'S MAIDEN NAME: Lottie -----

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT — ADDRESS
		Harry S. Moyer — 42 47th Ave San Francisco, Cal.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis & Myocard Degeneration Not Rheumatic. — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: At least 3 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis — DUE TO — ?

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Senility with Senile Dementia — ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 1, 1948, *to* February 1947, *that I last saw the deceased alive on* Feb. 2, 1949, *and that death occurred at* 3.40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Melvin M. Borden M. D.	2030 W Fayette St	2/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 5, 1949	Druid Ridge	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
FEB 4 1949	Remington for Williams, M.D.	H. H. Mears and Son 805 N Calvert St.

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

G71256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1 G71256

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rose Barbara Spicknall

2. DATE OF DEATH: 2-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for the Women of Md.

c. Length of stay in Baltimore: 71 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 102 Mt De Soles Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	1-15-78	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cincinatti, Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Weber

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myocardial Infarct	
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-31-49, 19__, *to* 2-3-49, 19__, *that I last saw the deceased alive on* 2-3-49, 19__, *and that death occurred at* 6:30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harvey Chesley Decker M. D.

23B. ADDRESS: Women's Hospital

23C DATE SIGNED: 2-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 2-5-49

24C NAME OF CEMETERY OR CREMATORY:

24D. LOCATION (City, town, or county) (State): Cincinnati, Ohio

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: George A. Farley ADDRESS: Fulton Ave & Fayette St

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

G71257 ✓ 449 G71257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bessie Sabella Keefer

2. DATE OF DEATH: 2-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 6420 Reisterstown Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Institute

c. Length of stay in Baltimore: 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14
D. STREET ADDRESS (If rural, give location): 2818 Westfield Ave. 27-07

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 7-26-91
9. AGE (In years last birthday): 57 — If Under 1 Year: Months 6, Days 7 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): bookkeeper
10B. KIND OF BUSINESS OR INDUSTRY: Towel Supply
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Harry Lewis
14. MOTHER'S MAIDEN NAME: Annie Keys
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS: The Seton Institute - 6420 Reisterstown Rd. Bltm

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebro-vascular Accident
DUE TO
(B) Hypertension, Severe

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) SENSORY CHANGES OF RIGHT HAND

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Eczematoid Dermatitis, Sensory Changes of L. Hand, Hypochromic Anemia, PSYCHOPATHOSIS

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 3, 1948 *to* Feb 3, 1949, *that I last saw the deceased alive on* Feb 3, 1949, *and that death occurred at* 2:03 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: George Winokur M. D.
23B. ADDRESS: Seton Institute
23C. DATE SIGNED: 2/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 2/7/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lasorsa Funeral Home — ADDRESS: 7101 Belair Rd.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and forcibly.

VS 150

83a

G71258

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.1 G71258

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William E. Brown

2. DATE OF DEATH: Feb. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 715 E. 41st. St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 715 E. 41st. St. 9-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 hours: Hours, Min.
Male	White	Widower	Aug. 18, 1865	83 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired painter	Balto. Transit Co.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	none	Mrs. S. J. King, 715 E. 41st. St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO arteriosclerosis with cerebral thrombosis causing hemiplegia (rt.)

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct. 1, 1948 *to* Feb. 1, 1949, *that I last saw the deceased alive on* Feb. 1, 1949, *and that death occurred at* 6:15 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lloyd C. Taylor M. D.	3902 Greenmount	Feb. 2 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	2/5/49	Cathedral Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	[illegible] for Williams, M.D.	H. Vernon Lemmon	4611 Park Heights

VS 150

8

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully given. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71259 ✓ 181 260 G71259

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print) John B. Carroll

2. DATE OF DEATH 2-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2929 Windsor Ave.,

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2929 Windsor Ave., 15-47

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	March 16,1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	B.& O. R.R.	Baltimore, Md.	

13. FATHER'S NAME J. Bond Carroll

14. MOTHER'S MAIDEN NAME Annie Angermann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs.Kathryn B.Carroll	2929 Windsor Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of Bladder	6 mo
DUE TO (B)	Diabetes	4 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Cardiac Asthma	4 hrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
Operated by Dr Austin Ward -		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 1, 1949, to Feb 3, 1949, *that I last saw the deceased alive on* 2/3, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Asher Cohen M. D.	1202 St Paul St	2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2-7-49	Loudon Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 4 1949	Evelyn Williams, M.D.	J. Howard Strong	3207 W. North Ave.

VS 150

46F

G71260 ✓ 422.2 G71260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Will Anderson

2. DATE OF DEATH: 2-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1207 Upton St

c. Length of stay in Baltimore: 2 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1207 Upton St. 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
M	C	M	1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Tobacco	Lawrenceville Va.	U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	240-09-1737	Helen Anderson - 1207 Upton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-29, 1949, *to* 2-3, 1949, *that I last saw the deceased alive on* 1-31, 1949, *and that death occurred at* 5:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Campbell M. D.	718 Dolphin St.	2-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2-5-49	City Cemetery	Rocky Mount N.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 5 1949	Huntington Williams, M.D.	Samuel W. Sullivan Jr.	Balto. Md

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71261 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157 Registered No. G71261

1. NAME OF DECEASED (Type or Print): PAULINE BALDWIN

2. DATE OF DEATH: Feb. 4 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Kentucky
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Versailles
D. STREET ADDRESS (If rural, give location): 1916 SPRING DRIVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	white		7-6-71	77	6	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		KENTUCKY	U.S.A.

13. FATHER'S NAME: P. Du Pont
14. MOTHER'S MAIDEN NAME: Ellen Coleman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) respiratory failure
DUE TO
(B) Carcinoma of pancreas ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
arteriosclerosis & cachulmalacia

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/11, 1949 *to* 2/4, 1949, *that I last saw the deceased alive on* 2/4, 1949, *and that death occurred at* 9 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature], M.D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
CREMATION	2-5-1949	GREENMOUNT	BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 5 1949
REGISTRAR'S SIGNATURE: Justin Jos Williams, M.D.
25. FUNERAL DIRECTOR: HENRY W. JENKINS ADDRESS: 4905 York Rd.

VS 150

469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71262 Esh

H20.1

G71262

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71262

1. NAME OF DECEASED (Type or Print): Calvin Richardson

2. DATE OF DEATH: FEB 3 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 78 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1017 N. Broadway 7 0 4

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.
Male	White	MARRIED	1-1-71	78

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hat Maker		Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? ?	? ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction due
DUE TO Hypertensive cardiovascular
disease with atherosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ✓ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 1·30·, 1949 *to* 2·3, 1949 *that I last saw the deceased alive on* 2·3·, 1949, *and that death occurred at* 1245 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Collins Harvey	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	2-5-49	PARKWOOD	TAYLOR AVE.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 5 1949	Huntington Williams, M.D.	JOHN F. DENNY, INC. 715 LIGHT ST - 30

VS 150

939

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G71263 ✓ 415 G71263

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) William S. Fann
2. DATE OF DEATH Feb 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1915 Edmondson ave
C. Length of stay in Baltimore 28 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1915 Edmondson ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto md 20 01
D. STREET ADDRESS (If rural, give location) 1915 Edmondson ave

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
m	c	married	Sept 27, 1898	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	—	Ga	

13. FATHER'S NAME James Fann
14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Beatrice Fann	1915 Edmondson ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Myocarditis — (INTERVAL BETWEEN ONSET AND DEATH) 12 mos
DUE TO
(B) Ard Arteriosclerosis with Hypertension
DUE TO
(C) Exposure & work

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* ____ *m., from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James R. Blake M.D.	603 N. Caroline	2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/5/49	Mt Calvary	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 5 1949	Emily Jo Williams M.D.	George G. Nelson	203 Braddish Ave

VS 150

93c

G71264 ✓ A 422.1 G71264

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) EMMA TRACEY

2. DATE OF DEATH 2/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ARDLEIGH NURSING HOME

c. Length of stay in Baltimore — Yrs. 4 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY HARFORD
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NORRISVILLE
D. STREET ADDRESS (If rural, give location) 3075 - Rockmere Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	DIVORCED	FEB-26-1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) BALTIMORE CO. MD
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME DORSEY COOPER
14. MOTHER'S MAIDEN NAME RACHEL MAYS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT — ADDRESS Wm. M. COOPER, WHITE HALL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection - Inquiry *Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE John R Davis M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED 2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE FEB 6-49
24C. NAME OF CEMETERY OR CREMATORY MIDDLE TOWN. MD
24D. LOCATION (City, town, or county) Balto Co (State)

DATE RECEIVED BY LOCAL REGISTRAR FEB 5 1949
REGISTRAR'S SIGNATURE Justin for Williams M.D.
25. FUNERAL DIRECTOR — ADDRESS Howard S. Hamblin

937

G71265 ✓ 443 416 G71265

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MIRIAM ROTHSCHILD.

2. DATE OF DEATH: 2/3/1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland. Green Spring Manor Apts.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 73 Yrs. —Mos. —Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Green Spring Manor Apts. 17-20

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 11/14/1875.
9. AGE (In years last birthday): 73 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bernard Moses
14. MOTHER'S MAIDEN NAME: Amelia Fried.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Weinberg, ADDRESS: Woodholme Ave. Pikesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO
(B) Rheumatic fever — years
DUE TO
(C) Hypertensive arteriosclerotic Cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Spring, 1947. *to* February 1949 *that I last saw the deceased alive on* 3 Feb., 1949, *and that death occurred at* 1 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis H. Hamburger Jr. M. D.
23B. ADDRESS: 1207 Eutaw Place.
23C. DATE SIGNED: 2/3/1949.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/6/1949.
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Hebrew
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 5 1949
REGISTRAR'S SIGNATURE: [illegible] Williams M.D.
25. FUNERAL DIRECTOR: Hurd Tomasemin & Son — ADDRESS: 1902 Eutaw Place.

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G71266 ✓ 420.1 G71266

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ALEXANDER HECHT.

2. DATE OF DEATH: 2/4/1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland Emersonian Apts.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 82 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Emersonian Apts. 13-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Married	1/15/1867	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Executive	Department Store	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Samuel Hecht, Jr.
14. MOTHER'S MAIDEN NAME: Babette Wolfsheimer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No		Mrs. Selma H. Hecht, Emersonian Apts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary thrombosis & Myocardial Infarction and Congestive heart failure — Interval between onset and death: 1 month

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Coronary artery sclerosis

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Generalized arteriosclerosis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January, 1949, *to* February, 1949 *that I last saw the deceased alive on* 4 Feb., 1949, *and that death occurred at* 9:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis H. Hamburger, Jr. M. D.	1207 Eutaw Place (17)	4 Feb. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Entombment	2/6/1949.	Baltimore Hebrew	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 5 1949	Huntington Williams, M.D.	David Hamburger & Son 1902 Eutaw Place.

VS 150

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Parrott
2. DATE OF DEATH: 2/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
C. Length of stay in Baltimore: 4 hours (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27 (Elkridge)
D. STREET ADDRESS (If rural, give location): 2119 Laudon Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Single	2/4/49			4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore Md	U.S.A.

13. FATHER'S NAME: Mr. Albert George Parrott
14. MOTHER'S MAIDEN NAME: Mildred Ruth Riggleman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Mrs. Mildred Parrott	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory Failure
DUE TO
(B) Prematurity.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) 5½ mo's gestation

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/4 *19*49 *to* 2/4 *, 19*49 *that I last saw the deceased alive on* 2/4 *, 19*49 *, and that death occurred at* 12:15 P.M. *, from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William J. Womack M.D.	Bon Secours Hospital	2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	Feb-6-1949	MEADOW RIDGE CEMETERY	WASHINGTON BLVD. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 5 1949	[illegible]	Thomas J. Kenny, Inc.	1600 Hollins St

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G71268

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.1 G71268

Registered No.

1. NAME OF DECEASED (Type or Print): William J. MacCubbin

2. DATE OF DEATH: Feb. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1307 E Lafayette Ave.
c. Length of stay in Baltimore: 79 Yrs. 0 Mos. 6 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1307 E Lafayette Ave. 9 09

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 1-28-1870
AGE (In years last birthday): 79
If Under 1 Year: Months 0 Days 6 Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Watchman
10B. KIND OF BUSINESS OR INDUSTRY: Race Track
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas MacCubbin
14. MOTHER'S MAIDEN NAME: Agnes Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs Eleanor F. Ward
ADDRESS: 1307 E Lafayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio-Vascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/15, 1949 *to* 2/3, 1949 *that I last saw the deceased alive on* 2/1, 1949 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry J. Blum M. D.
23B. ADDRESS: 1105 N. Calvert St
23C. DATE SIGNED: 2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-7-1949
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 5 1949
REGISTRAR'S SIGNATURE: Initials for Williams, M.D.
25. FUNERAL DIRECTOR: Elmer W. Conklin
ADDRESS: 924 E. Eager St.

VS 150

937

BIRTH NO. 671268

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 592 671269

1. NAME OF DECEASED (Type or Print): Roy C. Thurston

2. DATE OF DEATH: Feb. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Greene Lombard

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: 11 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lansdowne
D. STREET ADDRESS (If rural, give location): 2016 Sulphur Spr. Rd.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	July-15-1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Boilermaker	B&ORR	Virginia	USA

13. FATHER'S NAME: Elmer P. Thurston

14. MOTHER'S MAIDEN NAME: Dora Wood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown / yes-W.W. 1	205-07-5166	C R Thurston (son)	1009 Woodington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
ANTECEDENT CAUSES
(B) chronic glomerular nephritis
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-1-, 1949 *to* 2-4-49, 19-, *that I last saw the deceased alive on* 2-4-, 1949, *and that death occurred at* 3:20 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: John Hays Rosser, M. D. | 23B. ADDRESS: University Hospital | 23C. DATE SIGNED: Feb 4 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-7-49	Mt Moriah	Whitehall-Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 5 1949	Wm. J. Williams, M.D.	Stewart Morris Company	Balto.

VS NO 6

131B

Please write plainly, with unfading ink. Every item of information should be carefully correct age is especially important. Physician: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

671270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. 671270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 S. Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 S. Payson St. 24 03
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA S. PRINCE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife late Charles S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1876

8. AGE: Years	Months	Days	If less than one day
73	0	5	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. F.R. Wagner
(b) Address 7 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7 '49 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Fred'k Ave

18 (a) Funeral director Henry A Withe
(b) Address 4101 Edmondson Ave
(c) (Date rec'd by registrar) Huntington Williams Mar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3/1949, at 11 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17/1948, to 2/3/1949, and that I last saw h[illegible] alive on Jan 1 1949.

Immediate cause of death	Duration
Cerebral Hemorrage	6 hrs.
Due to Hypertension	2-3 yr
Due to Arteriosclerosis	yr.
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. Lentz & Sons M. D.
Address 1933 W. Baltimore St. Date signed 2/4/49

VS 150

832

✓ 422.1

G71271

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71271

BIRTH NO. 9 a.m.

1. NAME OF DECEASED (Type or Print) Cornel V. Hammack

2. DATE OF DEATH Feb 3rd 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 405 E. 31st St.

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 405 E. 31st St. 12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Feb 13th 1866	82	11	20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Meat Cutter	Provision	Va.	

13. FATHER'S NAME Jacob Hammack

14. MOTHER'S MAIDEN NAME Mary Larrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Etta V. Hammack	405 E. 31st St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

16.

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Endocarditis & Myocarditis — about 2yrs.

DUE TO

(C) Arteriosclerosis — unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 22nd. 19 48 *to* Feb. 3rd. 19 49; *that I last saw the deceased alive on* Feb. 3, 19 49, *and that death occurred at* 10 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jos. W. Montgomery M.D.	401 E. 25th. St. Balto. 18, Md.	2/4/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/8/49	Prospect Hill	Front Royal Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 5 1949	[illegible]	Wm. Cook Inc.	1217 St. Paul st.

VS 150

927

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71272 ✓ 422.1 G71272

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): LIZZIE GRAY ADAMS CONWAY

2. DATE OF DEATH: Feb. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Methodist Home for the Aged

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 W. Rogers Ave. 2-15

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: July 20, 1863
9. AGE (In years last birthday): 85 yrs. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Caroline Co., Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James Adams
14. MOTHER'S MAIDEN NAME: Elizabeth Nichols
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO:
17. INFORMANT: Miss Miriam O. Coates ADDRESS: 2211 W. RogersAv.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(B) Arteriosclerosis — 20 years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 30, 1948 *to* Feb. 2, 1949, *that I last saw the deceased alive on* Feb. 2, 1949, *and that death occurred at* 1:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Arthur J Davies M.D.
23B. ADDRESS: 2004 33 St
23C. DATE SIGNED: 2-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/5/49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

939

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71273 ✓ 157 G71273

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Svatora

2. DATE OF DEATH February 3,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2417 E. Eager Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
none

c. Length of stay in Baltimore 60 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
2417 E. Eager Street 7 07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widow	Nov 25,1865	83				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife at home	none	Czechoslovakia	U.S.

13. FATHER'S NAME
Frank Melka

14. MOTHER'S MAIDEN NAME
Anna Peska

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		None	Edward Svatora	2417 E. Eager Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypostatic Pneumonia	Feb 1. 1949
DUE TO (B)	Carcinoma of Pancreas	Oct. 1. 1948
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1, 1948, *to* Feb 3, 1949, *that I last saw the deceased alive on* Oct 3, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William J. Lyons M. D.	831 W. Lanvale St	Feb 4 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 7.1949	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 5 1949	Huntington Williams, M.D.	2601-03-05 E. Madison St. Schimunek Funeral Home Inc.

VS 150

469

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71274

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 422.1

G71274

Registered No.

1. NAME OF DECEASED (Type or Print): Mary S. ~~Petrick~~ Petrik

2. DATE OF DEATH: January 4, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland Maryland. (erased)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland. (illegible) Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-02
D. STREET ADDRESS (If rural, give location): 904 Belnord Avenue, N.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	June 12, 1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	U.S.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT — ADDRESS: Mrs. Marie A. Nies, 904 N. Belnord Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral accident — INTERVAL BETWEEN ONSET AND DEATH: 2-3 - 8 days

DUE TO

(B) Arteriosclerosis, cerebral disease [illegible]

DUE TO

(C) Senility

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senile [illegible]

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-2, 19[illegible], *to* 1-4, 19[illegible], *that I last saw the deceased alive on* 1-4, 1949, *and that death occurred at* 3:12 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Tomaschefer M. D.	[illegible]	1-[illegible]

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/8/49	Parkwood Cemetery	3310 Taylor Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
FEB 5 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

93D

✓ X 587.0 G71275

G71275

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71275

1. NAME OF DECEASED (Type or Print): Hohlbein, John Albert (SR.)

2. DATE OF DEATH: Feb. 4, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's
c. Length of stay in Baltimore: 36 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ East Lansdowne
D. STREET ADDRESS (If rural, give location): 1st. Ave., (E. Lansdowne) Apt.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M.	W.	Married	Apr. 4, 1902	46	1	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Unemployed~~ Machinist
10B. KIND OF BUSINESS OR INDUSTRY: Gas Corp.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Hohlbein
14. MOTHER'S MAIDEN NAME: Anna M. Heim
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Ruth M. Hohlbein (Wife) ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Peritonitis
DUE TO
(B) Intrahepatic Biliary Obstruction
DUE TO
(C) Acute Chronic Pancreatitis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1/29/49
19B. MAJOR FINDINGS OF OPERATION: - Adhesions, Hemorrhage &-
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/28/ , 19 49 to 2/4 , 19 49, *that I last saw the deceased alive on* 2/4/ , 19 49, *and that death occurred at* 6:45a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: 2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Mon. 2/7/49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
24D. LOCATION (City, town, or county) (State): Anne Arundel Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams
25. FUNERAL DIRECTOR: G. Howard Evans ADDRESS: 1400 E. Pratt St. Balto.

VS 150

128 3 yrs mgl

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G7126 Ost 2

420.1 G7126

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Cleazer Hill

2. DATE OF DEATH: JAN 31 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 17 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 306 N. Ann St 1-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Married	2-4-95	53				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Va	

13. FATHER'S NAME: Crolly Hill

14. MOTHER'S MAIDEN NAME: ? ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

(B) Arteriosclerosis

DUE TO

(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 1-30-1949 *to* 1-31-1949, *that I last saw the deceased alive on* 1-31-1949, *and that death occurred at* 11:40 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: Sherman Wellinkoff M. D.

23B ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 2/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Feb. 5-1949	Arbutus Mem. Park	Arbutus Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 5 1949

REGISTRAR'S SIGNATURE: Beatrice Jos. Williams, M.D.

25. FUNERAL DIRECTOR: Elroy S. Wilson ADDRESS: 1000 Brantly ave

VS 150

94a

G71277 ✓ 961.5 G71277

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-02127 Registered No.

1. NAME OF DECEASED (Type or Print) Baby Boy Crockett

2. DATE OF DEATH 2/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Agnes Hospital
c. Length of stay in Baltimore — Yrs. — Mos. — Days 2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 75-05
D. STREET ADDRESS (If rural, give location) 1220 Inner Circle

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
m	W	Single	2/2/49	2 days	2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B KIND OF BUSINESS OR INDUSTRY —
11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edgar Crockett
14 MOTHER'S MAIDEN NAME Retha Angley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO —
17. INFORMANT St Agnes Hospital ADDRESS Baltimore Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematuraty Approx 33 weeks
DUE TO
(B) Premature seperation of placenta

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B MAJOR FINDINGS OF OPERATION — 20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. —
21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 2/2, 1949, *to* 2/4, 1949 *that I last saw the deceased alive on* 2/4, 1949, *and that death occurred at* 2 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D. — 23B ADDRESS St. Agnes — 23C DATE SIGNED 2/4

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE 2-5-49 — 24C. NAME OF CEMETERY OR CREMATORY Lorraine Park — 24D LOCATION (City, town, or county) Woodlawn (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 5 1949 — REGISTRAR'S SIGNATURE [signature] for Williams — 25. FUNERAL DIRECTOR G. Howard Strong — ADDRESS 3207 W. North Ave.

VS 150

160c

Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71278 ✓ X 177 G71278

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): George Melchior

2. DATE OF DEATH: 2/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pikesville
D. STREET ADDRESS (If rural, give location): 4208 Lowell Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	10/29/	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Harmon Melchior

14. MOTHER'S MAIDEN NAME: Catherine Ann ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs. Marion Van Schultz	4208 Lowell Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart disease with Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Generalized Arteriosclerosis

DUE TO (C) Carcinoma of Prostate

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R V Ramirez, M. D.	St. Agnes Hospital	2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/7/49	Baltimore	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 5 1949	Substitute for Williams, M.D.	Loring Byers	5005 Reisterstown Rd

VS 150

51B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

195 Registered No. G71279

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Michael Frank Zeigler

2. DATE OF DEATH: February 5, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Freedom
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	March 14, 1876	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Mail Carrier.	Pennsylvania	U. S.

13. FATHER'S NAME: John Zeigler

14. MOTHER'S MAIDEN NAME: Leah Strayer.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Mrs. Norbert Shaver	New Freedom, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia - bilateral lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Post-operative

DUE TO

(C) Neuro blastoma, adrenal (cell) - metastases to the brain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Left adrenal tumor

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-28-49	Amputation mid-thigh - left	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 26, 1949 *to* Feb. 5, 1949, *that I last saw the deceased alive on* Feb. 5, 1949 *and that death occurred at* 6:20 AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Joseph Kagin M. D.	1400 N. Caroline Street	Feb. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Febr 5, 1949	New Freedom Pa.	New Freedom, Penna.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 5 1949	Evelyn Williams, M.D.	Jacob Bartenstein	New Freedom Pa.

VS 150

55a

G71280 BALTIMORE CITY HEALTH DEPARTMENT 331 G71280

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Josephine Reed

2. DATE OF DEATH: February 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1816 Maryland Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1816 Maryland Ave

c. Length of stay in Baltimore: 12 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1504 Rutter Street 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Widowed	Aug 2, 1892	56	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	—	King Queen Co. Va.	America

13. FATHER'S NAME: William Johnson

14. MOTHER'S MAIDEN NAME: Lantica Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	None	Mary Scott	1816 Maryland Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage (left)	2 wks
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Malignant Hypertension	8 1 yr.
DUE TO		
(C)	Cardiac Failure	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-22, 1949 *to* 2-5, 1949, *that I last saw the deceased alive on* 2-5, 1949, *and that death occurred at* 7:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Franklin Collins M. D.	1413 Penna. Ave	2/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		First Baptist Church	King & Queen County

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 6 1949	Municipal Registrar	Arthur Roane	Catonsville

VS 150

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8 3a

Correct age is especially important. Physician: please write the cause of death clearly and fully.

(2) G71281

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 422.1 592 G71281 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GERTRUDE M. SEXTON

2. DATE OF DEATH 2/3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3204 Hawkins Point Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3204 Hawkins Pt. Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married	Feb 21, 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Home	Maryland	USA.

13. FATHER'S NAME Joseph WAGNER

14. MOTHER'S MAIDEN NAME BARBARA SCHMUCK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—	—	—	MR DANIEL CERMAK	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio Sclerosis & Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 14 years

DUE TO

(B) Chronic nephritis — 4 months

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1935, *to* Feb. 3rd, 1949 *that I last saw the deceased alive on* Feb. 2, 1949, *and that death occurred at* 2.30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. McDermott M. D. M. O.	1136 Poplar Grove St	2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/7/49	Holy Cross	Annapolis Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 6 1949	[redacted]	John J. Denny Jr	715 Light St

VS 150

1310

Correct age is especially important. Physician: please write the cause of death clearly and fully.

G71282 ✓ 420.1 G71282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Elmer Horsey

2. DATE OF DEATH: Feb. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 717 E. 41st Street
c. Length of stay in Baltimore: About 84 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 717 E. 41st Street 9 61

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	-------	About 84	-- --	-

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
None	-------	Baltimore, Md.	

13. FATHER'S NAME: John Owens Horsey

14. MOTHER'S MAIDEN NAME: Hannah Thomas Pancoast

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT ADDRESS
		Mrs. Georgie L. Horsey 717 E. 41st

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pulmonary edema	2 weeks.
DUE TO (B)	Myocardial Failure	1 month
DUE TO (C)	Coronary Arteriosclerosis	?
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Urinary Retention	9 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1947 to Feb, 1949, *that I last saw the deceased alive on* Jan 30, 1949, *and that death occurred at* 11 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Thomas J. Brennan M. D.	5217 Harford Road	2-5-49

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D LOCATION (City, town, or county) (State)
Burial	2/8/49	St. John's	Waverly

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 6 1949	[illegible]	W. A. Weaks [illegible]

VS 150

94a

Please write the cause of death clearly and correct age is especially important. Physician:

AB-30676 G71283

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

002 G71283

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rayfield Wright

2. DATE OF DEATH Jan. 31-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 742 Pierce Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore Life Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Widowed	Feb. 12- 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waiter		Maryland	U.S.

13. FATHER'S NAME Andrew Wright

14. MOTHER'S MAIDEN NAME Ida Steward

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
			Baltimore City Hospitals Records-4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis, bilateral, far advanced

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Syphlis, old treated

INTERVAL BETWEEN ONSET AND DEATH: 6yrs. plus

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 3-31- , 1943, *to* 1-31- , 1949 *that I last saw the deceased alive on* 1-31- , 1949, *and that death occurred at* 6.35A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
G. A. Rogers M. D.	Baltimore City Hospitals	Feb. 4-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	2/6/49	Sacred Heart German Hill Rd	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 6 1949	Evangeline Williams	John J. Fahey Sons	

VS 150

13B

cause of death clearly and legibly.

G71284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71284

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catherine Moran

2. DATE OF DEATH: Feb. 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore — B. COUNTY: Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maryland
D. STREET ADDRESS (If rural, give location): 1200 Valley St. 10-01

5. SEX: F — 6. COLOR OR RACE: W. — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S.

8. DATE OF BIRTH: Dec. 20, 1869 — 9. AGE (In years last birthday): About 80 yrs — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Ireland — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Bernard Moran

14. MOTHER'S MAIDEN NAME: Cath. Dillon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Sister Superior ADDRESS 1200 Valley St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO

(B) Arteio Sclerosis — 10 yrs

DUE TO

(C) Chronic Nephritis — 5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 10 1948 *to* Feb 3, 1949, *that I last saw the deceased alive on* Feb 3 1949, *and that death occurred at* 9 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: E Gill Hall MD M. D. — 23B. ADDRESS: 1631 E North ave — 23C. DATE SIGNED: 2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify) — 24B. DATE: Feb 7 1949 — 24C. NAME OF CEMETERY OR CREMATORY: Cathedral — 24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE — 25. FUNERAL DIRECTOR — ADDRESS: Rita Weidefeld 900 E. Biddle St

FEB 6 1949

131a

Correct age is especially important. Physician please write the cause of death clearly and legibly.

G71285 ✓ 420.1 G#1285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BENJAMIN SOYPHER

2. DATE OF DEATH: 2-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4200 Pall Mall Road
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4200 Pall Mall Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH
9. AGE (In years last birthday): 73 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Isadore
14. MOTHER'S MAIDEN NAME: Mollie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Maurice Soypher — ADDRESS: 2400 Lakeview Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Pulmonary edema	2 hours
DUE TO		
(B)	Coronary thrombosis	One week
DUE TO		
(C)	General arterio sclerosis & hypertension	

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 27 – 1949 *to* Feb-5- 1949 *that I last saw the deceased alive on* Feb-5- 1949, *and that death occurred at* 6:00 *A.M., from the causes and on the date stated above.*

23A. SIGNATURE: Dr. Herman Leidt, M. D.
23B. ADDRESS: 2404 Eutaw Pl
23C. DATE SIGNED: 2/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-6-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 6 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Jack Levine — ADDRESS: 2100 Eutaw Pl

VS 150

FEB 6 1949

94a

Please write the cause of death clearly and legibly. Exact age is especially important. Physician:

G71286 ✓ G71286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

754 b Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jeffrey Lowe.

2. DATE OF DEATH: 2-5-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W Australia
B. COUNTY: Australia
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mount Lawley
D. STREET ADDRESS (If rural, give location): 56 Alan Boulevard

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	8-29-44	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Australia	Australia

13. FATHER'S NAME: Abraham Lowe.

14. MOTHER'S MAIDEN NAME: Annie Polistina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease and Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

DUE TO

(B) Pneumonia - Left — 4 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1-31-49

19B. MAJOR FINDINGS OF OPERATION: Pulmonic Stenosis - Right Blalock performed

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 21, 1949 *to* Feb. 4, 1949 *that I last saw the deceased alive on* Feb. 4, 1949 *and that death occurred at* 3:45 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 2/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	2-9-49		Houston Texas

DATE RECEIVED BY LOCAL REGISTRAR: FEB 6 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Jack Lewis Inc — ADDRESS: 2100 Eutaw Pl

VS 150

FEB 6 1949

157E

✓ 422.1 G71287

G71287

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary J. Curran

2. DATE OF DEATH: 2-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1933 E. North Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto Md. — COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1933 E. North Ave
D. STREET ADDRESS (If rural, give location): 1933 E. North Ave. 8-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	1868	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home.	—	Balto, Md. -	

13. FATHER'S NAME: Thomas B. Cross

14. MOTHER'S MAIDEN NAME: Mary J. Ratcliff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr. Wm. J. McGinnis — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	General Arteriosclerosis	5 years
DUE TO (B)	Myocardial Insufficiency	2 weeks
DUE TO (C)		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December 6, 1943 *to* February 3, 1949, *that I last saw the deceased alive on* February 2, 1949, *and that death occurred at* 505A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert Eisenberg M. D.	2025 East North Ave	February 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-7-49	Cathedral Cem.	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
FEB 6 1949	Initialed for Williams, M.D.	WIEDEFELD AND SON, GREENMOUNT AVE. & 22nd ST.

VS 150

937

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71288 B-110790 ✓ 002 G71288

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Arthur Herzog

2. DATE OF DEATH: Feb. 4-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 22 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 902 St.Paul Street 11-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Sept-12-1910	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DESK-CLERK- HOTEL.-
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ridgely, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Charles Herzog
14. MOTHER'S MAIDEN NAME: Mattie Day (D
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records- ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis, Bilateral
DUE TO Far Advanced.
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-20- , 19 47 *to* 2-4- , 19 49 *that I last saw the deceased alive on* 2-4- , 19 49 *and that death occurred at* 4.30P *m., from the causes and on the date stated above.*

23A. SIGNATURE: P. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: Feb. 4-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-7-49.
24C. NAME OF CEMETERY OR CREMATORY: CATHEDRAL.
24D. LOCATION (City, town, or county) (State): CITY

DATE RECEIVED BY LOCAL REGISTRAR: FEB 6 1949
REGISTRAR'S SIGNATURE: Registrar for Williams, M.D.
25. FUNERAL DIRECTOR: WIEDEFELD & SON. ADDRESS: GREENMOUNT AVE 22ND

FD-150

13B

G71289 ✓ 422.1 G71289

BALTIMORE CITY HEALTH DEPARTMENT 592

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EUGENE B. COLEMAN

2. DATE OF DEATH: 2/4/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6000 Bellona ave. Edgewood Nursing Home

c. Length of stay in Baltimor Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2918 Cresmont ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	Widowed	May 21, 1863	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Railroad Mechanic	Western Maryland R.R.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: John W. Coleman

14. MOTHER'S MAIDEN NAME: Amelia Miles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	none	Mrs. Virginia Coleman	Sudsburg 2918 Cresmont ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis

DUE TO

(B) Arteriosclerosis

DUE TO

(C) & Chronic Nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 7, 1948 *to* Feb 4, 1949 *that I last saw the deceased alive on* Feb 4, 1949 *and that death occurred at* 6:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[illegible] M.D.	117 W. 25th St.	Feb 5. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/7/49	New Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 6 1949	Beatrice [illegible] Williams, M.D.	Chas. J. Evans Son, Inc.	118 N. Mt. Royal Ave. 13

VS 150

0

Please write the cause of death clearly and correct age is especially important. Physician:

G71290 ✓ 1561 G71290

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Frances Fiedler
2. DATE OF DEATH: Feb. 3, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 129 N. Rose St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 129 N. Rose St. b c ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Nov. 6, 1870	78	2	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	House-Work	Baltimore, Md.	

13. FATHER'S NAME: Joseph Wagner
14. MOTHER'S MAIDEN NAME: Maria Stark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	—	Andrew J. Fiedler 9. S. Bowley St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Liver — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Dec 10, 1948 to Feb 3, 1949, that I last saw the deceased alive on Feb 3, 1949 and that death occurred at 5:45 a. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis Kramer M. D.	11 E. Chase St.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-7-49.	Holy Redeemer Cem.	4430 Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR, ADDRESS
FEB 8 1949	Huntington Williams M.D.	Charles S. Zeiler, 901 S. Bowling St.

VS 150

46F

Correct age is especially important. Physician: please write the cause of death clearly and fully.

✓ 416

G71291 BALTIMORE CITY HEALTH DEPARTMENT G71291

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): SALVATORE SERIO
2. DATE OF DEATH: 4 FEB 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY
c. Length of stay in Baltimore: 48 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BALTO
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO
D. STREET ADDRESS (If rural, give location): 3405 Elgin Ave 15 48

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	W		15 OCT 1886	62	3	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PRODUCE, REAL ESTATE →		Italy	U.S.A.

13. FATHER'S NAME: JOSEPH SERIO
14. MOTHER'S MAIDEN NAME: ROSE DEMARCO

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
UNK		WIFE	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Rheumatic Heart Disease	44 YRS
DUE TO (B)	CARDIAC FAILURE	
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING I.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☐ NO ✓

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4 JAN, 1949, *to* 4 FEB, 1949, *that I last saw the deceased alive on* 4 FEB, 1949, *and that death occurred at* 120 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A Ferris M. D.	Mercy Hospital	4 FEB 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 7-49	Cathedral	Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 6 1949	Williams, M.D. for Registrar	Riggel Bros.	1800 E. Lombard St.

95D

✓ 331 G71292

G71292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELLA LLOYd

2. DATE OF DEATH 2-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3457 Hickory Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3707 Arcadia Ave 27-18

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH -1-69 | 9. AGE (In years last birthday) 80 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown Cochran

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Mrs Ruth Sterns ADDRESS 3400 Hickory Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO

(B) Arteriosclerosis — 10 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Jan 31, 1949, to Feb 2, 1949, *that I last saw the deceased alive on* Feb 2, 1949, *and that death occurred at* 12:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Arthur J. Evans M. D. | 23B. ADDRESS 2000 E 33rd St. | 23C. DATE SIGNED 2-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Feb 7-49 | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Pk Cem. | 24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 6 1949 | REGISTRAR'S SIGNATURE [illegible] for Williams, M.D. | 25. FUNERAL DIRECTOR Grand H. Lentz | ADDRESS 814 W 36th St.

VS 150

83a

G71293

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

141 G71293

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Leo E. Thompson

2. DATE OF DEATH: Feb 4 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 451 Pitman Place
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 3702 Belmont Ln Balto Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 451 Pitman Place 12 05

5. SEX	6. COLOR OR RACE	7. SINGLE, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		Feb 29 1908	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bar Tender	Tavern	Baltimore Md.	Yes.

13. FATHER'S NAME: Harry T. Thompson

14. MOTHER'S MAIDEN NAME: Cenie McCHugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Lawrence McHugh 423 Homeland Ca

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of Tongue	1 yr.
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	None	
DUE TO		
(C)	-	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	-	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-26, 1949 *to* 2-5, 1949, *that I last saw the deceased alive on* 2-5, 1949, *and that death occurred at* 2:40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P. D. Flynn M. D.	11 E. Chase St.	2-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-7-49	New Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Huntington for Williams, M.D.	John C. Moran	3000 E Balto St

VS 150

45B

Please write the cause of death clearly and legibly. Physician: please specify important

671294

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

819.4 E 803. N

Registered No. 671294

BIRTH NO. E

1. NAME OF DECEASED (Type or Print): JOAN MELZER

2. DATE OF DEATH: Feb. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 3122 Woodhome Avenue 27-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	March 5. 1934	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore.Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Erhardt T. Melzer
14. MOTHER'S MAIDEN NAME: Edna A. Wroten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. Erhardt T. Melzer ADDRESS: 3122 Woodhome Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull

(B) Intracranial hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [ ] NO [X]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Old Harford Rd., 138' north Kildaire Dr.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: 2-5-49 2:10 a. m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Auto. into electric pole (deceased-passenger)

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from* Autopsy, Inspection or Inquiry *the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 2-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/8/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Taylor Ave., Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949
REGISTRAR'S SIGNATURE: Winifred Williams, M.D.
25. FUNERAL DIRECTOR: Howard N. Blight Jr. ADDRESS: 6009 Harford Road

VS 151

170C

G71295 City Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

770.7 G71295

BIRTH NO. B.C. 49-01590 Registered No.

1. NAME OF DECEASED (Type or Print): Charles Fisher

2. DATE OF DEATH: 2/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: 9 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN: Baltimore City (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1804 W. Franklin St. (23)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	Single	1/24/49		9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
infant	infant	Maryland	

13. FATHER'S NAME: Charles O. Fisher

14. MOTHER'S MAIDEN NAME: Mary Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Mrs Beatrice Brown	1804 W. Franklin

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

DUE TO (B) Cardiac failure — less than 36 hrs

DUE TO (C) Cardiac dilatation, cause unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(1) Hemorrhage (nominal) from nose & mouth — 0

(2) Jaundice: physiologic or hemolytic — less than 36

(3) Bronchopneumonia

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* 2/2, 1949, *and that death occurred at* 4:45 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. A. Hankins M. D.	University Hospital	2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		University Medical School	FEB 4 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Huntington Williams, MD	Commissioner of Health	

VS 150

107

G71296 ✓ 420.1 G71296

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MAY - LOHRMANN

2. DATE OF DEATH: Feb 5 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2784 Alameda Blvd
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2784 Alameda Blvd
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 2784 Alameda Blvd
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 9 0 1 Baltimore Md
D. STREET ADDRESS (If rural, give location): 2784 Alameda Blvd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Widowed	May 1. 1867	81	8 / 4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	—	Baltimore Md	

13. FATHER'S NAME: James Cragg

14. MOTHER'S MAIDEN NAME: Margaret Short

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no		Anna F. Von Hagel	2784 Alameda Blvd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	2 hrs
DUE TO (B)	Arteriosclerotic Cardio Vascular Disease & Hypertension	27 Sept-46
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 27 Sept, 1946 *to* 5- February 1949 *that I last saw the deceased alive on* 5- Feb, 1949, *and that death occurred at* 1.30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas W. Edmonds M. D.	2746 Alameda Blvd	5- Feb-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 8-1949	London Park	Balto - Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Huntington Williams, M.D.	Mr. Mrs. John H. Smith Son	2311 Edmondson Ave

VS 150

937

G71297 McCARDELL ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

522 Registered No. G71297

BIRTH NO. B. C. H. 45629

1. NAME OF DECEASED (Type or Print) HESTER MCCARDLE LL

2. DATE OF DEATH February 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 928 Druid Hill Avenue 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
female	colored	~~Widowed~~	July 3 1944	4				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Leroy McCardell

14. MOTHER'S MAIDEN NAME Mattie Mulligan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Leroy McCardell.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Upper respiratory failure — DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED Feb. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Feb 4 1949

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY [illegible]

24D. LOCATION (City, town, or county) (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 7 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR A. Hartley ADDRESS 928 Druid Hill Ave.

VS 151

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71298 ✓ 442 G71298

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED. (Type or Print) Alice Virginia Brady

2. DATE OF DEATH 2-5-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1833 Brentman St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1833 Brentman St.

C. Length of stay in Baltimore 6 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15 Ward
D. STREET ADDRESS (If rural, give location) 1833 Brentman St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	3/7/1869	79	10 / 28	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Carroll Co. Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Courtey	Deborah Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Lt. Col. Mrs. M. Brady	1833 Brentman St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Renal Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — 4 mos.

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 1, 19 49, *to* Feb 5, 19 49, *that I last saw the deceased alive on* Feb 5, 19 49, *and that death occurred at* 12:10 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis A. Hesson M. D.	2329 Gough St	Feb 7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/10/1949	Arbutus Mem. Gdns.	Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Huntington Williams, M.D.	Wm. Geo. A. Halland	Dennis Mill Cross

VS 150

1312

Caution: Be especially important. Physician: please write the cause of death clearly and legibly.

G71299 ✓ 490 G71299

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B.C.H.-22267 Registered No.

1. NAME OF DECEASED (Type or Print): Ronald Preston Foy
2. DATE OF DEATH: FEB 5 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 636 S. Carey, St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	colored	Child	10-7-48		3			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: William Alton Foy
14. MOTHER'S MAIDEN NAME: Dorothy Page.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	PNEUMONIA, LOBULAR,	15 days
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	TETANY, INFANTILE	16 Days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-23-1949 *to* 2-5-1949, *that I last saw the deceased alive on* 2-5-1949, *and that death occurred at* 4:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	JOHNS HOPKINS HOSPITAL	2-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 7, 1949	Woodmont Cemetery Co.	Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Huntington Williams, M.D.	Wm. George H. Holland	Druid Hill Ave

VS 150

107

CERTIFICATE CORRECTED 2-16-49 ✓ 422.1

G71300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71300

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph S. Knapp Jr.

2. DATE OF DEATH: 2/4/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 713 Homestead St.

c. Length of stay in Baltimore: 74 yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 713 Homestead St. 9 05

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	3/17/1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Accountant	Stevens Co. - Anderson	Maryland	USA

13. FATHER'S NAME: John Knapp

14. MOTHER'S MAIDEN NAME: Victoria Swinney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-07-0881

17. INFORMANT: Mrs Joseph S. Knapp Jr. ADDRESS: 713 Homestead St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	4 hrs.
DUE TO (B)	Arteriosclerosis	unknown
DUE TO (C)	Myocarditis	unknown
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 4th. 1949 *to* Feb. 4th. 1949, *that I last saw the deceased alive on* Feb. 4th 1949, *and that death occurred at* 11:20 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jos. W. Murgatroyd M. D.

23B. ADDRESS: 401 E. 25th. St. Balto. 18, Md.

23C. DATE SIGNED: 2/5/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): 24B. DATE: 2/8/49

24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cem

24D. LOCATION (City, town, or county) (State): Greenmount Cem

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949

REGISTRAR'S SIGNATURE: Remitting for Williams, M.D.

25. FUNERAL DIRECTOR: John J. Cowan & Son ADDRESS: 90 Hollins St.

VS 150

93D

G71301 ✓ 420-0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No. G71301

1. NAME OF DECEASED (Type or Print): Anna Emmel

2. DATE OF DEATH: 2/6/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1702 Belvedere Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1702 Belvedere Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widow	Oct. 6th, 1862	86	3	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore County

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Frederick Overlander

14. MOTHER'S MAIDEN NAME: Unknown Tainey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Charles Emmel ADDRESS: 2817 Ailsa Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) arteriosclerotic Heart Disease — 5 years.

DUE TO

(C) bronchial arteriosclerosis — 10 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 3, 1949 *to* Feb. 5, 1949 *that I last saw the deceased alive on* Feb. 5, 1949 *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. Sawyer M. D.

23B. ADDRESS: 4808 Harford Rd.

23C. DATE SIGNED: 1/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 2/8/49

24C. NAME OF CEMETERY OR CREMATORY: Jerusalem Lutheran

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Lassahn Funeral Home ADDRESS: 7401 Belair Rd.

VS 150

93D

G71302 ✓ E903.5 N854.0 G71302

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) ADAM DESPEAUX

2. DATE OF DEATH February 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore DOA Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 515 South Collington Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	Married	1/30/1907	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Baltimore	USA

13. FATHER'S NAME: Adam Despeaux

14. MOTHER'S MAIDEN NAME: Laura Noff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Yes	World War II	

17. INFORMANT: Emma Despeaux — ADDRESS: 515 S. Collington Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Subarachnoid Hemorrhage, traumatic	
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Alley	Rear of 500 S. Collinton Avenue 1/4

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Feb. 4, 1949 ? p.m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Slipped and Fell while intoxicated

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Carl L. Payne M.D.	[X]	Feb. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/8/1949	Baltimore National Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
FEB 7 1949	Huntington Williams, M.D.	Lilly & Zeiler, Inc. 403 S. Wolfe St.

VS 151

186a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71503 ✓ 420.1 G71503

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Joseph Schoestrand

2. DATE OF DEATH 2/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore 9 Yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.
D. STREET ADDRESS (If rural, give location) 5116 CRAIG AVE. 27 10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	MARRIED	12-29-1889	59 59	1	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ENGINEER	INSURANCE	ENGLAND	U.S.A.

13. FATHER'S NAME HANS OLAF SCHOESTRAND

14. MOTHER'S MAIDEN NAME ELIZABETH OLIVER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	120-01-5166	DONALD SCHOESTRAND	5116 CRAIG AV

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
John R Davis M.D.		2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	2-7-1949	LOUDON PARK	BALTO., MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Huntington Williams, M.D.	H. W. JENKINS & SONS	4905 YORK RD

VS 151

94a

Cause age at capacity, impairment, physician please write the cause of death clearly and legibly.

G71304 E819-4 N828.6 G71304

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): JOHN MATTINGLY

2. DATE OF DEATH: February 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 50 yrs Mos. 7 Days 11

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 415 S. Clinton St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Feb 15-1882	05		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Optician	Eye Glasses	St Marys Co Md	

13. FATHER'S NAME: Walter E Mattingly

14. MOTHER'S MAIDEN NAME: Martha Dawson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	—	212-09-3344	Mrs Queen M. Mattingly	Ruxton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia.

DUE TO (B) Contusion of base of brain. Fractured fibula, tibia, patella, radius, and ribs. Laceration of chin.

DUE TO (C) History of recent accident

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Eastern Ave. and East Falls Ave. 3/2

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 27, 1949 12:50 a m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Auto. into wall (deceased-passenger)

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Feb. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 8 1949	Mt Maria	Towson Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Huntington Williams, M.D.	Henry A Jenkins & Sons	4905 York Rd

VS 151

1700

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G71.05 Dr. Himelfarb 1801 Eutaw Place

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 G71.305 Registered No.

1. NAME OF DECEASED (Type or Print): Theresa Agnes Nuth

2. DATE OF DEATH: Feb. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3919 Parkside Drive
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3919 Parkside Drive 2 / 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	Aug. 1, 1905	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	at home	Baltimore, Maryland	

13. FATHER'S NAME: John F. Krein

14. MOTHER'S MAIDEN NAME: Mamie Walter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		Mr. Henry J. Nuth, 3919 Parkside Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CARCINOMA OF BREAST.	8 yrs.
DUE TO (B)		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
1941	CARCINOMA OF LT. BREAST	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1941, *to* Feb. 3, 1949, *that I last saw the deceased alive on* Feb 3, 1949, *and that death occurred at* 6 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert Himelfarb M. D.	1801 Eutaw Pl	Feb 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2-7-49	Holy Redeemer	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
FEB 7 1949	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

50

G71306 ✓ 446 490 G71306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 86827

BIRTH NO.

1. NAME OF DECEASED (Type or Print): PIERPONT, Benjamin Franklin

2. DATE OF DEATH: Feb. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ---- (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 519 Dennison St., Baltimore, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Wid.	Nov. 27, 1897	51	2	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shipping clerk	----	Howard Co., Md.	USA

13. FATHER'S NAME: Benjamin Pierpont

14. MOTHER'S MAIDEN NAME: Julia Wise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW I 9/3/18-1/25/19	Unk.	Records- US Marine Hospital, Balto., Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, lobar, both lower ~~XXXX~~ lobes — Interval between onset and death: Less than 2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Nephrosclerosis with hypertension- DUE TO — Duration unknown

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 30, 1948 *to* Feb. 4, 1949, *that I last saw the deceased alive on* Feb 4, 1949, *and that death occurred at* 11:10 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson
John L. Wilson, Clinical Dir. Sr. Surg. P.H.S.

23B. ADDRESS: U.S. Marine Hospital, Balto., Md.

23C. DATE SIGNED: 2/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE: Feb 8 '49

24C. NAME OF CEMETERY OR CREMATORY: Mem Cathedral

24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949

REGISTRAR'S SIGNATURE: Evelyn Williams, M.D.

25. FUNERAL DIRECTOR: Harry A Wiltze

ADDRESS: 4101 Edmondson Ave

VS 150

108

✓ Y 162

671307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 671307

BIRTH NO.

1. NAME OF DECEASED (Type or Print): David Edward Lipps

2. DATE OF DEATH: Feb 5 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: Frederick
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Frederick
D. STREET ADDRESS (If rural, give location): 211 E. 5th St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Divorced		54 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber		Frederick, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas S. Lipps	Martha Poffinberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		University Hospital	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Tosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Probably Primary Bronchogenic Carcinoma

DUE TO

(C) Malnutrition

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 4 1949 *to* Feb 5 1949 *that I last saw the deceased alive on* Feb 5 1949, *and that death occurred at* 8 30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank E Brunback M. D.	University Hospital	2/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/8/49	Mt. Olivet	Frederick, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 7 1949	Thurlington Williams, M.D.	M. R. Etchison & Son Frederick, Md.

VS 150

47c

329043 331 026

G71308 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71308 Registered No.

1. NAME OF DECEASED (Type or Print): Noona F. Wilkins
2. DATE OF DEATH: 2/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hosp.
c. Length of stay in Baltimore: 48 4 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19
D. STREET ADDRESS (If rural, give location): 17 N. Calhoun St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 8-28-00
9. AGE (In years last birthday): 48 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Simon Hoffman
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Herbert S. Wilkins 17 North Calhoun St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 Hrs.
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Nervous System Syphilis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/4 1949 to 2-5- 1949 that I last saw the deceased alive on 2/5 1949 and that death occurred at 12 25 A M., from the causes and on the date stated above.

23A. SIGNATURE: Richard S Rosa M.D.
23B. ADDRESS:
23C. DATE SIGNED: 5 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 8 1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cem
24D. LOCATION (City, town, or county) (State): Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: Roth C & B M. Walker Proctor Stuckey Sts

30c

G71309 ✓X 492 G71309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELIZABETH LOUISE SCHAEFER

2. DATE OF DEATH 05 FEB 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN HOSP

c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) OWINGS MILLS
D. STREET ADDRESS (If rural, give location) REISTERSTOWN ROAD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
FEMALE	WHITE	SINGLE	26 SEPT 1948		4	10	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INFANT	—	BALTIMORE, MD.	U.S.

13. FATHER'S NAME ERNEST SCHAEFER

14. MOTHER'S MAIDEN NAME MARIE HARTLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
NO —	NONE	MOTHER AND FATHER

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ATYPICAL PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 9 DAYS
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES X NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
—		

22. *I hereby certify that I attended the deceased from* 01 FEB, 1949 *to* 05 FEB, 1949, *that I last saw the deceased alive on* 04 FEB, 1949, *and that death occurred at* 105 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald L. England M.D.	MARYLAND GEN. HOSP	5 FEB 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	FEB 7 49	NEW CATHEDRAL	BALTO

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Hunting for Williams	J. HEEMANN & SON	6067 HARFORD RD.

VS 150

1092

Caution: Age is especially important. Physician: please write the cause of death clearly and legibly.

G71310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 90 30 N 80 7.0

Registered No. G71310

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clara S. Jones

2. DATE OF DEATH: 2/5/49 5:28 a.m.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 403 Whitridge Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 403 Whitridge Ave 12 C 3

5. SEX	6. COLOR OR RACE	7. ~~SINGLE, MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Sept 12 1872	76	5	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	Self	Balto. Co. Md.	

13. FATHER'S NAME: Joseph T. Phelps

14. MOTHER'S MAIDEN NAME: Mary Rosa Hedrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Elsie Henderson ADDRESS: 403 Whitridge Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Pulmonary Oedema	48 hrs
DUE TO		
(B)	Fractured S-9 Ribs (Left)	3 wks
DUE TO		
(C)	Virus Pneumonia Related	4 wks
	Arteriosclerotic Cardiovascular disease	

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUSE LAST.

CERTIFICATION APPROVED BY

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
accident	home	403 Whitridge Avenue 12/3

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
1-15-49 ? p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Lost balance and fell to floor

22. *I hereby certify that I attended the deceased from* 31 Dec 1948 *to* Feb 5 1949, *that I last saw the deceased alive on* Feb 5 1949, *and that death occurred at* 5:28A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Howard L Zepp M. D.	427 Hopkins Rd Balto 12	

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	2/8/49	Woodlawn	Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1949

REGISTRAR'S SIGNATURE: Remington for Williams

25. FUNERAL DIRECTOR: Wm Bok Inc. ADDRESS: 127 St. Paul St

VS 150

186a

G71311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

903.0 G71311

BIRTH NO. N 820 Registered No.

1. NAME OF DECEASED (Type or Print): MINNIE HARDING

2. DATE OF DEATH: 2/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL

C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2529 WINDSOR RD #14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W		11/12/72	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		PENNSYLVANIA	U.S.A

13. FATHER'S NAME: JOSEPH E. DE LEON

14. MOTHER'S MAIDEN NAME: MIRIAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		RICHARD HARDING	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) BRONCHO-PNEUMONIA

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) FRACTURE NECK, L. FEMUR

DUE TO

(C)

CERTIFICATION APPROVED BY
for: C.J. Lubinski, M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

SENILITY, DECUBITUS ULCER

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12/18/48	FRACT. NECK OF L. FEMUR	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
ACCIDENT	HOME	2529 WINDSOR RD.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
11/26/48 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	FELL ON FLOOR

22. *I hereby certify that I attended the deceased from* 11/29 19 48 *to* 2/5 , 19 49 *that I last saw the deceased alive on* 2/5 , 19 49 *and that death occurred at* 7 25 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul G. Herold M.D.	Maryland General Hosp.	2/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/9/49	Cedar Bluff	Annapolis, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Henrietta for Williams, M.D.	Wm Cook	1217 St Paul St

VS 150 must be approved by medical examiner

186a

G71312

BALTIMORE CITY HEALTH DEPARTMENT 420.1 G71312

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH P. GODFREY

2. DATE OF DEATH: Feb. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1222 Brentwood Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1222 Brentwood Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
Male	White	Married	Mar. 20, 1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Warehouseman	Railway Express Co.	New Jersey	

13. FATHER'S NAME: Patrick Godfrey

14 MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs. Mamie Godfrey	1222 Brentwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3½ hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) —

DUE TO

(C) —

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT —

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 19 49 *to* Feb. 4, 19 49, *that I last saw the deceased alive on* Feb. 4, 19 49, *and that death occurred at* 10:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C DATE SIGNED
Samuel Lilienfeld M. D.	714 E. Preston St	Feb 5

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/8/49	Meadow Ridge	Dorsey, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR ADDRESS
FEB 7 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

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G71313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ X A43 G71313

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Emma C. Sollers

2. DATE OF DEATH: Feb 4/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hosp.
c. Length of stay in Baltimore: 56 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rockdale
D. STREET ADDRESS (If rural, give location): 8120 Liberty Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (Years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Married	Sept 4, 1892	56	5	0		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	U.S.

13. FATHER'S NAME: Christian F. Heinlein

14. MOTHER'S MAIDEN NAME: Mathilde Boehm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			James T. Sollers	8120 Liberty Road Rockdale Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Cerebral Hemorrhage	30 hrs.
DUE TO (B)	Hypertensive Cardio-Vascular Disease	
DUE TO (C)		

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 3, 1949 *to* Feb 4, 1949 *that I last saw the deceased alive on* Feb 4, 1949 *and that death occurred at* 5:40 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm E. Peters Jr. M.D.	St. Josephs Hosp.	2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/7/49	Druid Ridge	Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Huntington Williams M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 150

927

G71314 ✓ 15-04 155 G71314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) HARRY BAUM

2. DATE OF DEATH 2-6-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balt. Md.
D. STREET ADDRESS (If rural, give location) 2100 Whittier ave

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W

8. DATE OF BIRTH
9. AGE (In years last birthday) 72
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Morris

14. MOTHER'S MAIDEN NAME Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Esther Baum ADDRESS 2100 Whittier Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancer of Gall Bladder — Unknown
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
(C) Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION Jan 31, 1949
19B. MAJOR FINDINGS OF OPERATION Cancer of Gall Bladder
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 20, 1949 to Feb 6, 1949, *that I last saw the deceased alive on* 2-6-49, 1949, *and that death occurred at* 12 Noon *from the causes and on the date stated above.*

23A. SIGNATURE Leonard Katz M.D.
23B. ADDRESS Sinai Hosp.
23C. DATE SIGNED 2-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 2-7-49
24C. NAME OF CEMETERY OR CREMATORY Rosedale
24D. LOCATION (City, town, or county) Balto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 7 1949
REGISTRAR'S SIGNATURE Thomas Augustine Williams, M.D.
25. FUNERAL DIRECTOR Jack Rewis Inc ADDRESS 2100 Eutaw Pl

VS 150

46F

G71315

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

260

G71315

Registered No.

1. NAME OF DECEASED (Type or Print): Barney Shrog

2. DATE OF DEATH: Feb. 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Church Home & Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

C. Length of stay in Baltimore: 19 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Baltimore
B. COUNTY: Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
D. STREET ADDRESS (If rural, give location): 330 Pine Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	M	April 1, 188[illegible]	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Grocer	Grocery	Russia	

13. FATHER'S NAME: Abram Shrog

14. MOTHER'S MAIDEN NAME: Sina Katz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Self	above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 19 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Diabetes Mellitus — 15 yrs.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 1-18-49, 1949, *to* 2-6, 1949, *that I last saw the deceased alive on* 2-6, 1949, *and that death occurred at* 7:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
I. Robert Haase M. D.	Church Home & Hosp.	6 Feb 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb, 7. 1949	Hebrew Herring Run Cem	Bowleys Lane Balto MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	[illegible] Williams, MD	Sol Levinson & Bros	1124 W North Ave

VS 150

61

G71316

420.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71316

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) FANNIE PRICE

2 DATE OF DEATH Feb. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2034 N. Washington St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md.
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 1761 Darley Ave. 8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year Months Days	If under 24 hours Hours Min.
female	white	Widow	April 20, 1875	73 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper		Kent Co., Md.	

13. FATHER'S NAME Benjamin F. Downes

14 MOTHER'S MAIDEN NAME Mary B. Britton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
-	-	Mr. Edgar B. A. Bosley	1206 Lakeside Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Occlusion.	sudden.
DUE TO (B)	Arteriosclerosis etc.	-
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 1, 1949 *to* Feb 5, 1949 *that I last saw the deceased alive on* Feb 4, 1949, *and that death occurred at* 9 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M Bauman Lloyd M. D.	2200 Garrison Blvd	2-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/8/49	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Huntington Williams	WM. J. TICKNER & SONS	Balto., Md.

VS 150

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G71317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

353.1 420.1 G71317

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ferdie James

2. DATE OF DEATH: Feb. 6th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2504 Manhattan Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3504 Manhattan Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Married	March 15th 1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Myohl	Kate Shuster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Capt. Edward James	2504 Manhattan Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — Interval between onset and death: 2 hrs.
DUE TO
(B) Coronary Sclerosis Myocardites Chronic
DUE TO
(C) Epilepsy Grand Mal — 2 yrs
DUE TO
Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 20 1948 *to* Feb 6 1949, *that I last saw the deceased alive on* Feb 6 1949 *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thurman Starks M. D.	2601 Maunsbury Ave	Feb. 6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 9 1949	Druid Ridge Cem	Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Hunter for Williams, MD	William J. Pickner & Sons	North & Pa. Ave

VS 150

6

931

G71318 Pd 6 ✓ 420.1 G71318

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Alexander Skierkowski
2. DATE OF DEATH: FEB 1 - 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 40 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1522 Clinton St
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: ? ? 1892
9. AGE (In years last birthday): 56 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Skierkowski
14. MOTHER'S MAIDEN NAME: Josie ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 215-05-7710
17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — DUE TO

(B) Arteriosclerotic cardiovascular — DUE TO

(C) Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-4 1949 *to* 2-4 1949, *that I last saw the deceased alive on* 2-4 1949 *and that death occurred at* 9³⁰ *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: John Collins Harvey M. D. | 23B. ADDRESS: JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED: 2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Feb. 8-1949 | 24C. NAME OF CEMETERY OR CREMATORY: Holy Cross | 24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949 | REGISTRAR'S SIGNATURE: Thurston Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS: Wm. S. Fialkowski

VS 150

93D

G71319 Battersby ✓ 181 G71319

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Mary E. Battersby

2. DATE OF DEATH Feb-6-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Edgewood Nursing Home

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2137 E Oliver St 504

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male FE	White	Widow	Oct. 7-1870	78	3	30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto. Md	

13. FATHER'S NAME James M Price

14. MOTHER'S MAIDEN NAME Louisa Ford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Herbert B Shriver	2137 E Oliver St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of Bladder	6 months
DUE TO (B)	Metastasis in Lungs	1 month
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 10 *, 1949, to* Feb 6 *, 1949, that I last saw the deceased alive on* Feb 5 *, 1949, and that death occurred at* 11-45 *A.M., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E Gill Hall M.D. M. D.	1631 E. North Ave	Feb-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/8/49.	Balto. Cem	North Ave - Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Acting for Williams, M.D.	John C. Mellyson	2435 E Oliver St

VS 150

52 B

G71320 ✓ 422.1 G71320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Carrie Worthan WORTHMAN
2. DATE OF DEATH: 2/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D-A John Hopkins Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 8 Ward
D. STREET ADDRESS (If rural, give location): 1803 N. Patterson Park Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	MARRIED	January 10, 1894	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.

13. FATHER'S NAME: John Klaunberg
14. MOTHER'S MAIDEN NAME: Caroline Hofmeister

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		George Worthman 1803 Patterson Pk. Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C V disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: C. J. Sulkowski M.D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 2/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	Feb. 8, 1949	Baltimore Cemetery	East North Ave. Ext.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 7 1949	Interim for Williams, Md	Leo G. Cook 1701-03 Patterson Park Ave.

VS 151

93D

G71321 ✓ 331 G71321

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Isabell Mitchell

2. DATE OF DEATH Feb 4th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1409 N. Chester
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1409 N. Chester St 804

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Widowed	June 26th 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Maher	Alice Nelson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. D. Roach	1409 N. Chester St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral hemorrhage. L. Hemiplegia	4 weeks
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Arteriosclerosis. Arterial Hypertension.	3 yrs.
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 27, 1948 *to* Feb. 4, 1949 *that I last saw the deceased alive on* Feb. 1, 1949 *and that death occurred at* 9.45A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature]	1613 Eutaw Ave.	2-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2/8/49	Baltimore	E. North Ave. East

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Huntington for Williams, M.D.	Leo G. Cook	1703 N. Patterson Park Ave

VS 150

839

671322 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

819.4 671322 Registered No. 803

1. NAME OF DECEASED (Type or Print): RICHARD GALLAGHER

2. DATE OF DEATH: February 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2042 Orleans Street 604

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white		April 2 1931	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plumber		Balto	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard Gallagher	Frances Shumsky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Frances Shumsky	2042 Orleans

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

(B) Contusion of Brain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	street	Old Harford Rd. 138 ft. north Kildaire Dr.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
2-5-49 2.10 a. m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	auto into fixed object

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
Earl L Power M.D.		Feb. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Feb 8 49	Cathedral Cem	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Huntington Williams, M.D.	Welsh & Funeral Home	2008 Orleans

VS 151

170c

671323 ✓ 1544 671323

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Grimmel

2. DATE OF DEATH Feb 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp

C. Length of stay in Baltimore life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1216 E Oliver St. 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. If under 1 year, months, days. If under 24 hours, hours, min.)
M	W	Widower	May 6, 1873	75

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?		Baltimore	

13. FATHER'S NAME John Grimmel

14. MOTHER'S MAIDEN NAME Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
		Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 9 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of rectum

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2/1/49	Ca of rectum	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/28 1949, *to* 2/5 1949, *that I last saw the deceased alive on* 2/5 1949, *and that death occurred at* 8 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. Siwinski M. D.	Mercy Hospital	2/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feby 8-1949	LoudonPark Crm	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
FEB 7 1949	Huntington Williams, M.D.	Ulrich Funeral Home 2008 Orleans

VS 15a

467

✓002

671524 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 671524

1. NAME OF DECEASED (Type or Print): Mamie M. Atkins

2. DATE OF DEATH: Feb 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4622 Falls Rd.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balty
D. STREET ADDRESS (If rural, give location): 4622 Falls Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
F	C	married	May 3, 1917	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		md	

13. FATHER'S NAME: Albert Johnson

14. MOTHER'S MAIDEN NAME: Ruth Swann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Calvin atkins	4622 Falls Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Pulmonary Atelectasis
DUE TO
& pneumonia
(B)
DUE TO
Encapsulating Pericarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Instant / Weeks or / Years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11/24/48 19 *to* 2/4/49 19, *that I last saw the deceased alive on* 2/4/49 19 *and that death occurred* 7 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. L. Burkhardt M. D.	626 N. Carey St	2/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2/7/49	Mt Zion cem.	anne arundel Co. md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	[illegible]	George S. Kelson	1303 Presstman St

VS 150

6

12C

G71325 CERTIFICATE CORRECTED 2-10-49x ✓162 G71325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 87075

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Petri, Fred

2. DATE OF DEATH: Feb. 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: New York B. COUNTY:

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Park Dr.& 31st St. Baltimore, Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buffalo

D. STREET ADDRESS (If rural, give location): Worth Hotel

c. Length of stay in Baltimore: Yrs. -- Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
m	w	Single	Aug. 19, 1892	56	5	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook	Seafaring	California	USA

13. FATHER'S NAME: Peter Petri

14. MOTHER'S MAIDEN NAME: Marie Miss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	--	Unk.	Records-US Marine Hospital, Balto., Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Careinoma of the ~~left~~ right lung with metastases — Interval between onset and death: Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Jan. 12, 1949 *to* Feb. 5, 1949 *that I last saw the deceased alive on* Feb 5, 1949 *and that death occurred at* 8:10 *m., from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson, Sr. Surgeon, Clinical Director — M. D.

23B. ADDRESS: US Marine Hospital, Balto., Md.

23C. DATE SIGNED: 2/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/8/49	~~U.S. National~~ St. Peters	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	26. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Huntington Williams, M.D.	Wm Cook Inc.	127 St Paul St.

VS 150

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G71326 ✓X 151 G71326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Wheeler, James
2. DATE OF DEATH: Feb 6 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 1519 Division Street
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hospital
c. Length of stay in Baltimore: Yrs. 6 Mos. 0 Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY Charles C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Springhill D. STREET ADDRESS (If rural, give location) —
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: 9/7/1885
9. AGE (In years last birthday): 63 (If under 1 year: Months —, Days —; If under 24 hours: Hours —, Min. —)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Newbury Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS: Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1/22/49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of stomach
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/1, 1949 *to* 2/[illegible], 1949, *that I last saw the deceased alive on* 2/7, 1949, *and that death occurred at* 2.45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Dr Mowry W. Moore, Sr M. D.
23B. ADDRESS: President Hospital
23C. DATE SIGNED: 2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-9-1949
24C. NAME OF CEMETERY OR CREMATORY: Newbury
24D. LOCATION (City, town, or county) (State): Charles Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, MD
25 FUNERAL DIRECTOR: Mrs Katie R Williams & Funeral
ADDRESS 322 N.

46 B

G71327 ✓ 420.1 G71327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Jachson

2. DATE OF DEATH Feb.2.1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) I829 E. Eager St.

c. Length of stay in Baltimore 28 Yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RFD and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) I829 E. Eager St.

5. SEX	6. COLOR OR RACE	7. SINGLE MARRIED WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
Male	Col.	Widowed	Jan.29.I88I	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Janitor	Bethelhem Steel	Virginia	USA.

13. FATHER'S NAME Unkown

14 MOTHER'S MAIDEN NAME Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
			Louise Leach	I829 E. Eager St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 1 day
DUE TO
(B) Coronary sclerosis — 9
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory street, office bldg. etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2-1, 19 49 *to* 2-2, 19 49 *that I last saw the deceased alive on* 2-1, 19 49 *and that death occurred at* 10 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Stanford A. Saunders M.D	2309 Druid Hill Ave	7 Feb. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Feb.7.1949	Mt. Calvary Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Louis J. Williams, M.D.	Elroy O. Wilson	I000 Brantly Ave.

94a

G71328 BALTIMORE CITY HEALTH DEPARTMENT 4/20.0 G71328
CERTIFICATE OF DEATH
49 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY ANNE BOWERSOX
2. DATE OF DEATH FEBRUARY 7 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 603 ST. DUNSTANS RD.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore Yrs. 25 Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY CARROLL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) WESTMINSTER
D. STREET ADDRESS (If rural, give location) 21 JOHN

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	SINGLE	OCT. 22-1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEKEEPER	ST. JOHNS RECTORY	WESTMINSTER, MD.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ABSOLOM BOWERSOX	SUSAN FOWLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
NO		NONE	MRS A.C. BRANDT	603 ST. DUNSTANS RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CEREBRAL THROMBOSIS	3 DAYS
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)	ARTERIOSCLEROTIC HEART DISEASE, DECOMPENSATED	4 WEEKS
DUE TO (C)	GENERALIZED ARTERIOSCLEROSIS	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	VIRUS PNEUMONIA, BILATERAL	4 WEEKS

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
—	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* JANUARY 13, 1949, *to* FEBRUARY 7, 1949, *that I last saw the deceased alive on* FEB 5, 1949, *and that death occurred at* 8:45 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frederick J. Vollmer M. D.	6100 York Road	Feb 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	FEB 10-1949	ST. JOHNS CEMETERY	WESTMINSTER MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	(writing) for Williams, M.D.	H BANKARD + SON	WESTMINSTER MD.

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✓X 540.0

G71329

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71329

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRY C. TIMMERMAN
Henry C. Timmerman

2. DATE OF DEATH 5 Feb 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 109 Forest View Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	17 July 1878	70	6 / 18	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick layer
10B. KIND OF BUSINESS OR INDUSTRY →

11. BIRTHPLACE (State or foreign country) BALTO, MD.

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME BERNARD P. TIMMERMAN

14. MOTHER'S MAIDEN NAME ELIZABETH EILERS SCHMIDT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 217-05-3570

17. INFORMANT MARY T. TIMMERMAN ADDRESS 109 FOREST VIEW AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I
(A) Gastric Ulcer (Bleeding) — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(B) Generalized Arteriosclerosis — 10 years
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
4 FEB 1949	Bleeding Gastric Ulcer	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4 Feb, 1949, *to* 5 Feb, 1949, *that I last saw the deceased alive on* 5 Feb, 1949, *and that death occurred at* 5:50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Ferris M. D.	Mercy Hospital	5 Feb 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	FEBRUARY 8th 49	HOLY REDEEMER	4430 BELAIR RD MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 7 1949	Thomas J. Williams, M.D.	Doepel Bros. 7110 Belair Rd.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Howard Chambers

2. DATE OF DEATH: 2/4/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3616 Malden Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3616 Malden Ave. 13 08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	Unknown	about 73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Laborer.	Maryland.	

13. FATHER'S NAME: Charles Chambers.

14. MOTHER'S MAIDEN NAME: Caroline Mc Crosson.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-10-5599

17. INFORMANT: Mrs. Sarah Yake ADDRESS: 4669 Park Heights Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ..... DUE TO

(C) .....

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: John R D Ayres M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 2/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 8, 1949	St. Mary's, Hampden	Roland Ave, Balto co.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949

REGISTRAR'S SIGNATURE: Harding for Williams, MD

25. FUNERAL DIRECTOR: Euston E. Donovan ADDRESS: 3638 Roland Ave

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✓ 421.1

71331

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 71331

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret T. Coburn

2. DATE OF DEATH Feb 5 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3604 Garrison Blvd

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Md
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
d. STREET ADDRESS (If rural, give location) 3604 Garrison Blvd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. 77 yr, Mos., Days

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1871
9. AGE (In years last birthday): 77 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Balto.
12. CITIZEN OF WHAT COUNTRY? yes

13. FATHER'S NAME: Cornelius Coburn
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —

17. INFORMANT: Thomas Coburn ADDRESS: 3604 Garrison

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Edema. — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
ANTECEDENT CAUSES
(B) acute insufficiency — unreadable
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22 *I hereby certify that I attended the deceased from* Jan 5, 1949, *to* Feb 5, 1949 *that I last saw the deceased alive on* Feb 5, 1949, *and that death occurred at* 11 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: M Bunn and Kood M. D.
23B. ADDRESS: 2200 Garrison Blvd
23C. DATE SIGNED: 2-7-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: Feb. 8 1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Woodlawn

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949
REGISTRAR'S SIGNATURE: Hamilton for Williams
25. FUNERAL DIRECTOR: Chas. Tobbe & Son
ADDRESS: 2337 Edmon

VS 150

92a

G71382 ✓422.1 G71332

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): NETTIE LEON

2. DATE OF DEATH: Feb 6 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1502 Eutaw Pl.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 1502 Eutaw Pl. B. COUNTY 14-07
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Dec 1874	74	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Copel Rudavsky
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Esta Leon ADDRESS: 1502 Eutaw Pl

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Bronchopneumonia	one week
DUE TO (B)	Acute edema of lungs	4 weeks
DUE TO (C)	Myocarditis + Aortic insuf	?
	arteriosclerosis	

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 7, 1949 *to* Feb 6, 1949 *that I last saw the deceased alive on* Feb 6, 1949 *and that death occurred at* 11.50 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: B M Bernard M. D.
23B. ADDRESS: 3455 Park Heights Ave
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 8 1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Hebrew Cem
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Levinson Bros, ADDRESS: 1124 W North Avenue

VS 150

92a

G71333

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

332 Registered No. G71333

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Paul Anthony Sowa

2. DATE OF DEATH: Feb. 7, 49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp.

c. Length of stay in Baltimore: 35 Yrs. More Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24
D. STREET ADDRESS (If rural, give location): 1122 S. Kenwood Ave 1-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	3/17/75	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	Bakery	Polana	

13. FATHER'S NAME: Joseph Sowa

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Bertha Sowa — ADDRESS: 1122 S. Kenwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis
DUE TO
(B) Generalized Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Delirium Tremens.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 31, 1949, to Feb 7, 1949, *that I last saw the deceased alive on* Feb 7, 1949, *and that death occurred at* 5:30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M.D.
23B. ADDRESS: 1705 N. [illegible]
23C. DATE SIGNED: Feb 4, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 8 1949	St Stanislaus Cemetery	Dundalk Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949
REGISTRAR'S SIGNATURE: [illegible] Williams
25 FUNERAL DIRECTOR: John J. Wilda — ADDRESS: 2829 Hudson St

VS 150

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✓ X 334 G71334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G71334
BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harriett A.W.Webster

2. DATE OF DEATH: Feby 6.1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Hillcrest Nursing Home 212 Stoney Run Lane

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillsrest Norsing Home

c. Length of stay in Baltimore: 2 weeks (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Bel Air Md.
B COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Belair Md.
D STREET ADDRESS (If rural, give location): 212 Stoney Run Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
female	white	widow	Mch 29.1877	71	10 7	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Harford Co.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Steven A. Williams
14. MOTHER'S MAIDEN NAME: Ariel E. Street

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Wm. Webster — ADDRESS: Belair Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Vascular accident	2 wks
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) arteriosclerosis & Hypertension	2 yrs.
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 21, 1948, *to* Feb 6, 1949, *that I last saw the deceased alive on* Feb 4, 1949, *and that death occurred at* 9:11 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Frances W Slucr M. D.
23B. ADDRESS: 3406 St. Paul St
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feby. 8.1949
24C. NAME OF CEMETERY OR CREMATORY: Churchville Md.
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949
REGISTRAR'S SIGNATURE: Emily F. Williams
25. FUNERAL DIRECTOR: John O. Mitchell & Sons — John O. Mitchell
ADDRESS: 1900 EutawPlace

VS 150

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G71335 V022 G71335

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Antoinette Rakowsky — TENA Rock / TENA RAKOWSKI
2. DATE OF DEATH: 2/5/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: 55 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE: MD. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 216 S. WASHINGTON ST.
5. SEX: F
6. COLOR OR RACE: WH
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED
8. DATE OF BIRTH: MAY 5, 1893
9. AGE (In years last birthday) If Under 1 Year: Months Days. If Under 24 Hours: Hours Min.: 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINE OPERATOR
10B. KIND OF BUSINESS OR INDUSTRY: CLOTHING
11. BIRTHPLACE (State or foreign country): POZNAN, POLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: THOMAS GARDYAN
14. MOTHER'S MAIDEN NAME: MAGDALENE JANOWIAK ✓
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 216-09-9061
17. INFORMANT: THEODORE RAKOWSKI ADDRESS: 216 S. WASHINGTON ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Luetic Aortitis

DUE TO Aortic Aneurysm

(C) Multiple Pulmonary infarcts

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/31, 1948, *to* 2/5, 1949 *that I last saw the deceased alive on* 2/5, 1949, *and that death occurred at* 5:10 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marjorie Oxman M. D.
23B. ADDRESS: Sinai Hospital, Baltimore
23C. DATE SIGNED: 2/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/9/49
24C. NAME OF CEMETERY OR CREMATORY: HOLY CROSS
24D. LOCATION (City, town, or county) (State): ANNE ARUNDEL CO.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949
REGISTRAR'S SIGNATURE: Thomas for Williams, M.D.
25. FUNERAL DIRECTOR: M. F. SADOWSKI & SONS
ADDRESS: 1808 EASTERN AVENUE

VS 150

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G71336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jacob Hershe

2. DATE OF DEATH: Feb. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 2 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 111 N. Belnord Ave.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan 12 1858
9. AGE (In years last birthday): 91 85 ? (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John
14. MOTHER'S MAIDEN NAME: ? Margueth Trabert
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: B. C. H. Records, ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO
(B) C. V. Accident — 2 wks.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES Yes NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-2 , 1946 *to* Feb. 5 , 1949, *that I last saw the deceased alive on* Feb. 5, 1949, *and that death occurred at* 8.20 AM, *from the causes and on the date stated above.*

23A. SIGNATURE: G. K. Cooper M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: Feb. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/8/1949
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949
REGISTRAR'S SIGNATURE: [illegible] Williams
25. FUNERAL DIRECTOR: Randall J. Hoppel ADDRESS: 312 S. Highland ave.

VS 150

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G71337 ✓ 491 G71337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catherine E. Ross

2. DATE OF DEATH: Feb. 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Home

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 452 Furrow St.

c. Length of stay in Baltimore: 25 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 452 Furrow St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	Widowed	Jan. 5, 1865	84	1	1

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF (What country)
Home Duties		Rochester, N. Y.	

13. FATHER'S NAME: Charles Eidman

14. MOTHER'S MAIDEN NAME: Catherine Long

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		None	Lillian Hall	452 Furrow St. Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO
ANTECEDENT CAUSES
B) none
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
C) none

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/3, 1949 *to* 2/6, 1949 *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Miller MD M.D.	2030 Wilkens Ave	4/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town and county) (State)
Burial	2/9/49		Rochester N.Y.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Municipal Registrar	Frederick A. Cole	

VS 150 FEB 1949

107

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71338

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Peters

2. DATE OF DEATH: 2/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1125 Hull Street

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed	Oct. 28, 1882	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Rotterdam, Germany	

13. FATHER'S NAME: George Hoffman

14. MOTHER'S MAIDEN NAME: Dora

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		William F. Peters - Son	- Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

(B) Cardiac Failure

DUE TO

(C) Hepatic Cirrhosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/4 1949, *to* 2/4 1949 *that I last saw the deceased alive on* 2/4 1949, *and that death occurred at* 7:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	South Baltimore Gen. Hosp.	2/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	FEB. 8 1949	Cedar Hill	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	[illegible] Williams, M.D.	Thomas W. Singleton	

VS 150

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1242

G71339 ✓ 151 G71339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY HOHMAN

2. DATE OF DEATH: 4 FEB 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL

c. Length of stay in Baltimore: 50 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BALto
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTO
D. STREET ADDRESS (If rural, give location): 2537 McHenry St.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: 25 MAY 1889
9. AGE (In years last birthday): 59
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MINNESOTA
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JACOB Steinmel
14. MOTHER'S MAIDEN NAME: Mary Yaunker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: SON
ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 6 months (approx.)
DUE TO
(B) with abdominal metastases
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3 FEB 1949 *to* 4 FEB 1949, *that I last saw the deceased alive on* 4 FEB 1949, *and that death occurred at* 10 55 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: John A Ferris M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 4 FEB 49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: Feb 8-1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross Cem.
24D. LOCATION (City, town, or county) (State): Anundel County

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1950 1949
REGISTRAR'S SIGNATURE: Hunting for Williams, M.D.
25. FUNERAL DIRECTOR: Bernard C. Haile
ADDRESS: 121 E. West St

4613

G71540 ✓ 442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No. G71540

1. NAME OF DECEASED (Type or Print): Nellie T. Power

2. DATE OF DEATH: Feb. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1103 Barclay St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ----------
c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY: ----------
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1103 Barclay St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday) If under 1 Year Months Days If under 24 hours Hours Min.: About 70 --- -- -- --
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? ----------
13. FATHER'S NAME: Nicholas J. Power
14. MOTHER'S MAIDEN NAME: Elizabeth Canty
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No ----------
16. SOCIAL SECURITY NO: ----------
17. INFORMANT ADDRESS: Miss Elizabeth M. Power

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 18 Hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardio - Renal - Vascular Disease 10 yrs

DUE TO

(C) Hirschsprungs Disease 15 yrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1947, *to* Feb 6, 1949, *that I last saw the deceased alive on* Feb 5, 1949, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edward F. O'Donnell M. D.
23B ADDRESS: 230 York Rd
23C DATE SIGNED: 2/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B DATE: 2/9/49
24C NAME OF CEMETERY OR CREMATORY: New Cathedral
24D LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949
REGISTRAR'S SIGNATURE: Thomas J. Williams, M.D.
25 FUNERAL DIRECTOR ADDRESS: H. H. Mears and Son 805 N. Calvert St.

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G71341

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

572.2 G71341

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dolores Betty Johnston

2. DATE OF DEATH: February 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR (If not in hospital or institution, give street address or location): St. Josephs

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A STATE Md. B COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 3720 Fairhaven Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F.	W.	Married	Dec. 5, 1925	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore	

13. FATHER'S NAME: Jacob S. Haigis

14. MOTHER'S MAIDEN NAME: Delores H. Clardy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	220-18-5848	George Johnston	135 W. Clement St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized peritonitis — DUE TO

(B) Perforation of ileum — DUE TO

(C) ulcerative entero-colitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
Jan. 14 1949.	ulcerative Colitis	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 22, 1948 *to* Feb. 6, 1949 *that I last saw the deceased alive on* Feb. 6, 1949 *and that death occurred at* 2:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William P. Rodgers M. D.	1400 N. Caroline St.	Feb. 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 9, 1948	Holy Cross Cemetery	Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 7 1949	Assistant for Williams, M.D.	Krause Funeral Home 1216 S. Charles St.

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G71342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71342
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Terry Edward Fetty

2. DATE OF DEATH: February 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: W. Va.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
D. STREET ADDRESS (If rural, give location): Box 107

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Child	7-13-48		6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		W. Va.	

13. FATHER'S NAME: Edward Fetty

14. MOTHER'S MAIDEN NAME: Helen Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia - bilateral

DUE TO

(B) Upper respiratory infection

(C) Accidental ingestion Bar-

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
5. Feb. 1949	Aplasia pneumatosis intestinalis	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-18 1949 *to* 2-6 1949 *that I last saw the deceased alive on* 2-6 1949, *and that death occurred at* 4 45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. C. Fong M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
removal	2/7/49	New Martinsville	New Martinsville, West Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949		Wm. Cook, Inc.,	1217 St. Paul Street

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Entered in Wheeling, W. Va.

157M

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C. 49-02277

1. NAME OF DECEASED (Type or Print): Baby Farrell

2. DATE OF DEATH: 2/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3512 Fremont Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	2/6/49			1	7	10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Charles J. Farrell

14. MOTHER'S MAIDEN NAME: Lenore Olsen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: St Agnes Hosp Records ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Stenosis - congenital — INTERVAL BETWEEN ONSET AND DEATH: at birth

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/6, 1949 *to* 2/7, 1949 *that I last saw the deceased alive on* 2/7, 1949 *and that death occurred at* 8:55 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robt Lemmell M. D.	St Agnes	2/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/9/49	Ste. Peter's + Paul's	Cumberland, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 7 1949	Wm. [illegible] for Wm. [illegible]	Charles L. George	Cumberland, Md.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY LOUISE LUTZ

2. DATE OF DEATH: Feb. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1213 Havenwood Road
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1213 Havenwood Road 27 9

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Widow	Nov 10, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME: Frederick Brenner

14. MOTHER'S MAIDEN NAME: Anna M. Holdfer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Mrs Margaret E. Goessner	1213 Havenwood Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cer. Arteriosclerosis — DUE TO — 16 yrs.

(C) Pri hypertension

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1933 *to* Feb 7, 1949 *that I last saw the deceased alive on* Feb 7 - 1949, *and that death occurred at* 2:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. G. Geyer M. D.	1500 Eutaw Place	Feb 7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/9/49	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	[illegible] for Williams MD	William Cook, Inc.,	1917 St. Paul St.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): LOUISA A. WHITE

2. DATE OF DEATH: Feb. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2505 W. Lombard St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2505 W. Lombard St. 2 0 6 4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Married	Dec. 28, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME: Henry Arnold

14. MOTHER'S MAIDEN NAME: Anna E. Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No		Dr. William H. White, 2505 W. Lombard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Renal Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 14, 1948, *to* Feb 6, 1949, *that I last saw the deceased alive on* Feb 6, 1949, *and that death occurred at* 9 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert Seagrotta M. D.	1729 W Lombard St	2-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/9/49	National	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 8 1949	[illegible]	William Cook, Inc., 1217 St. Paul St.

VS 150

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71546 ✓002 G71546

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print)	Dewey	Geers	2. DATE OF DEATH 2-5-49

3. PLACE OF DEATH: A. Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A STATE Md. B COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
c. Length of stay in Baltimore Yrs. Mos. Days	D. STREET ADDRESS (If rural, give location) 38 S. Carey St. 19 03.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Widowed	Sept. 26, 1898	50 49	4	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Paris, Texas	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W. W. 2	None	Mrs Mary Geers,	1142 Montepelier st

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary Tuberculosis	
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Emil Beyer M.D.	☒	2-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	Feb 9 1949	Baltimore National	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	[illegible] Williams, M.D.	Frederick A. Cole	1300 W Lombard St

VS 151

13B

G71547 ✓ 420.1 G71547

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): IDA HIMELFARB
2. DATE OF DEATH: 2-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4203 Newbern Ave
C. Length of stay in Baltimore: 24 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4200 Newbern Ave 25-01

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 70
If under 1 Year: Months Days
If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Michael Berger
14. MOTHER'S MAIDEN NAME: Anda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs J. Friedman ADDRESS: 4203 Newbern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO

(B) Hypertensive Cardio-Vascular Disease — 8 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 15, 1946 to Feb. 7, 1949, that I last saw the deceased alive on Jan. 17, 1949, and that death occurred at 5.10p. m., from the causes and on the date stated above.

23A. SIGNATURE: Albert Himelfarb, M. D.
23B. ADDRESS: 1601 Eutaw Place
23C. DATE SIGNED: Feb 7. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-8-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 8 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): PHILIP P. WEISS

2. DATE OF DEATH: 2-7-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 808 Whitelock St

c. Length of stay in Baltimore: 40 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 808 Whitelock St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married		56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Dress	Romania	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Solomon	Eva

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT	ADDRESS
Yes World War I	217-16-0074	Etta Weiss	808 Whitelock Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary thrombosis	1 hr
DUE TO (B)	Coronary - sclerosis	3 years
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2-6 1949 *to* 2-7 1949, *that I last saw the deceased alive on* 2-7 1949, *and that death occurred at* 1:15 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. Harold N. Bix M. D.	2516 Linden Ave	2-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-8-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	Thomas E. Williams	Jack Reeves Inc	1100 Eutaw Pl

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DELIA W. Scott.

2. DATE OF DEATH: Feb. 5 / 49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto 2601 Manhattan Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md — B. COUNTY Balto — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore — D. STREET ADDRESS (If rural, give location) 2601 Manhattan Ave

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 9, 1864

9. AGE (In years last birthday): 84 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Carrollton Me

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Alois Wantz

14. MOTHER'S MAIDEN NAME: Charlotte Rineaman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown):

16. (If yes, give war or dates of service):

SOCIAL SECURITY NO.

17. INFORMANT: Sherman R Wantz M.D. — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Congestive Heart Failure	2 days
DUE TO	Myocarditis Chronic	10 yrs
(B)	Lupus Vulgaris	12 yrs.
DUE TO		
(C)	Bronchitis	3 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ — NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1937 to Feb. 5, 1949, that I last saw the deceased alive on Feb. 5, 1949, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE: Sherman R Wantz M. D.

23B. ADDRESS: 2601 Manhattan Ave

23C. DATE SIGNED: Feb. 7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): 2/8/49

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: London Park

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 8 1949

REGISTRAR'S SIGNATURE: Dorothy [illegible] Williams

25. FUNERAL DIRECTOR: Loring Byers — ADDRESS: 5005 Park Heights Ave

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Agnes G. Price

2. DATE OF DEATH: Feb. 7th, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 10 N. Pulaski St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: BALT.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Overlea, Md.
D. STREET ADDRESS (If rural, give location): 26 W. Elm Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	Jan. 11th, 1895	54		26	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James H. Graham

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Allan D. Price ADDRESS: 26 W. Elm Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of both breasts — INTERVAL BETWEEN ONSET AND DEATH: 9 mos

DUE TO 2 Metastases

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/6 48 *to* 2-7 49, *that I last saw the deceased alive on* 2-7 49 *and that death occurred at* 6 4 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph F Lawcarks M. D.	6 E Washington Blvd	2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	2/10/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	[illegible]	Lasaleh Funeral Home	7401 Belair Rd.

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G71:51 ✓ 420.1 G71:51

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3043 Spaulding Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 37-17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3043 Spaulding ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Silberman

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-9945A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
64				

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Printer
11. Industry or business

FATHER — 12. Name	Not Known
FATHER — 13. Birthplace	Poland
MOTHER — 14. Maiden Name	Not Known
MOTHER — 15. Birthplace	Poland

16 (a) Informant Sarah Silberman
(b) Address 3043 Spaulding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-49 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jos. Lewis Inc
(b) Address 2140 Eutaw Place

19 (a) FEB 8 1949 (Date received by Registrar) (b) Hunter for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1949, at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1949 to Feb 7 1949, and that I last saw h[illegible] alive on Feb 7 1949.

Immediate cause of death Coronary Thrombosis — Duration 20 minutes
Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel V. Josephson
Address 3600 Park Heights ave Date signed Feb 9, 1949

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correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G71352 ✓ 422.1 G71352

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print)	RUBY L. DUGAN
2. DATE OF DEATH	Feb. 6, 1949
3. PLACE OF DEATH: A.	Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	2420 N. Calvert St.
c. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D STREET ADDRESS (If rural, give location)	2420 N. Calvert St.
5. SEX	female
6 COLOR OR RACE	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	single
8. DATE OF BIRTH	Jan. 5, 1878
9 AGE (In years last birthday) / If under 1 year: Months / Days / If under 24 hours: Hours / Min.	71 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	—
10B. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country)	Chestertown, Md.
12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Albert J. Dugan
14 MOTHER'S MAIDEN NAME	Mary E. Parsons
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16 SOCIAL SECURITY NO	
17 INFORMANT / ADDRESS	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cardio Vascular Disease	2 yrs
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10 *,* 19 42 *, to* Feb 6 *,* 19 49 *, that I last saw the deceased alive on* Feb 6 *,* 1949 *, and that death occurred at* 1 15 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE	E. William Frey M. D.	
23B ADDRESS	1928 Penna Ave	
23C DATE SIGNED	2/8/49	
24A. BURIAL, CREMATION, REMOVAL (Specify)	Burial	
24B. DATE	2/9/49	
24C NAME OF CEMETERY OR CREMATORY	Western Cem.	
24D LOCATION (City, town, or county) (State)	Baltimore, Md.	
DATE RECEIVED BY LOCAL REGISTRAR	FEB 8 1949	
REGISTRAR'S SIGNATURE	[illegible] for Williams, M.D.	
25 FUNERAL DIRECTOR / ADDRESS	WM. J. TICKNER & SONS / Balto., Md.	

VS 150

93D

G71353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

G71353

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Lindsey, Mary

2. DATE OF DEATH: 2-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital
c. Length of stay in Baltimore: Yrs. 12 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Florida
B COUNTY: Pinellis
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dunedin
D STREET ADDRESS (If rural, give location): 300 San Salvador Drive

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 27, 1873
9. AGE (In years last birthday): 75 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: US
13. FATHER'S NAME: Kitson, George
14. MOTHER'S MAIDEN NAME: Haythorn, Elizabeth
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT ADDRESS: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gastrointestinal hemorrhage
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: Hours —

19A. DATE OF OPERATION: 2-1-49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma sigmoid colon
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-28, 1949, *to* 2-8, 1949, *that I last saw the deceased alive on* 2-8, 1949, *and that death occurred at* 23½ *m., from the causes and on the date stated above.*

23A. SIGNATURE: Richard M. Garrett M.D.
23B. ADDRESS: Church Home & Hosp
23C. DATE SIGNED: 8 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Entombment
24B. DATE: 2/11/49
24C. NAME OF CEMETERY OR CREMATORY: Harleigh Mausoleum
24D. LOCATION (City, town, or county) (State): Camden, N.J.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25 FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC. BALTIMORE, MARYLAND

VS 150

46E

✓422.1

G71354
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71354
Registered No.

1. NAME OF DECEASED (Type or Print): Barbara Dvorak

2. DATE OF DEATH: Feb. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4310 Southern Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 69 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-0
D. STREET ADDRESS (If rural, give location) 4310 Southern Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Widow	Nov. 30, 1860	88	2	6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Bohemia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Liposka
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT 43[illegible] ADDRESS [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Senility

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov., 1948 *to* Feb. 6, 1949, *that I last saw the deceased alive on* Feb. 6, 1949, *and that death occurred at* 6:28 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[illegible] M. D.	5400 Gwynn Oak Ave	Feb 7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 9, 1949	Holy Redeemer	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	[illegible] for Williams, M.D.	[illegible]	[illegible]

VS 150

937

G71355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

204.1(F) G71355

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) JENNIE F. WILKINSON

2. DATE OF DEATH FEB. 7 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3032 WALBROOK AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE —
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3032 WALBROOK AVE.

c. Length of stay in Baltimore 49 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 3032 WALBROOK AVE 15-06

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
FEMALE	WHITE		FEB 27 1855	93	11	7	4	15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) POCOMOKE CITY, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME THOMAS MATHEWS

14. MOTHER'S MAIDEN NAME SARAH WHITE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT J. Walter Wilkinson ADDRESS ROCK HILL BRANCH PASADENA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic Myocarditis	1 yr.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Chronic Myeloid Leukemia	5 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	DUE TO (C)	

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1942 *to* Feb. 6, 1949 *that I last saw the deceased alive on* Feb. 6, 1949, *and that death occurred at* 4.15 A m., *from the causes and on the date stated above.*

22A. SIGNATURE Jesse C. Dickson M. D.

23B. ADDRESS 305-6 W. North ave

23C. DATE SIGNED Feb. 7-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 2-9-49

24C. NAME OF CEMETERY OR CREMATORY Woodlawn

24D. LOCATION (City, town, or county) Woodlawn (State) Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 8 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Ellsworth Armacost ADDRESS 3911 Liberty Heights Ave

VS 150

74a

G71356

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

332 G71356
Registered No.

1. NAME OF DECEASED (Type or Print) **Edgar Hunter Lambert**	2. DATE OF DEATH **February 6th. 1949**
3. PLACE OF DEATH: A. **Baltimore City, Maryland** 523 N. Pulaski St B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Maryland** B. COUNTY (Baltimore) St. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** D. STREET ADDRESS (If rural, give location) **523 N. Pulaski St.** 50-01
c. Length of stay in Baltimore — Yrs. Mos. Days	

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	**White**	**Married**	**Apr. 29, 1877**	**71**	**9**	**7**		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Boilermaker	**B. & O. R. R.**	**Martinsberg W. Va.**	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Lambert	**Mary Lambert**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT **Wife** ADDRESS **Mrs. Cora J. Lambert 523 N. Pulaski St.**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) **Cerebral Thrombosis**	**3 yrs.**
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) **Arteriosclerosis**	**?**
DUE TO		
	(C) **Senility**	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* **Jan 15**, 19**44**, *to* **Jan. 6**, 19**49**, *that I last saw the deceased alive on* **Jan. 5** 19**49**, *and that death occurred at* **10.45 P.m.**, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. Langdale M. D.	**400 N. Payson St.**	**2/8/49**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**Feb. 9th. 1949**	**Reformed Church Cemetery**	**Middletown, Fred. Co. Md**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	**Huntington Williams M.D.**	**Geo. L. Beyer Jr.**	**1512 Hollins St.**

VS 150

8 3B

G71557 — 181 — G71557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William L. Bebloff

2. DATE OF DEATH: Feb 6-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1937 W. Baltimore St.

c. Length of stay in Baltimore: 14yrs. Yrs. Mos.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-07
D. STREET ADDRESS (If rural, give location): 1937 W. Baltimore St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 day: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	Aug. 17-1887	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	Housewares. —	Germany	U.S.R.

13. FATHER'S NAME: Peter Bebloff

14. MOTHER'S MAIDEN NAME: Margaret Porter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	215-03-7086	Elizabeth Bebloff	1937 W. Baltimore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Glioneuroid carcinomatosis. — 6 months

DUE TO: Carcinoma of the urinary bladder — 2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
April 1946	carcinoma of urinary bladder	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* December, 1947 *to* Feb 6, 1949 *that I last saw the deceased alive on* Feb 6, 1949, *and that death occurred at* 4:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm Michel M. D.	2901 Edmondson ave	Feb 8 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb-8-49	Loudon Park —	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	Counting for Williams, M.D.	G. B. Hyfield & Son	1900 Eutaw Pl.

VS 150

52B

EMRICH ✓ 323

G71358

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71358 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary E. Emrich

2. DATE OF DEATH: 2/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General

C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 631 S. Eutaw Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	May 1895	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Baltimore Md	USA

13. FATHER'S NAME: Wallace Nickol

14. MOTHER'S MAIDEN NAME: Margaret Zutzman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.

17. INFORMANT: Phillip W. Emrich ADDRESS: 631 S. Eutaw St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple arterial emboli. — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Mural Thrombus ? — ?

DUE TO

(C) Arterio-sclerotic cardio-vascular disease — 10 or more years

Hypotension

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Morphine Adiction

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 2/4 1949 to 2/7 1949, that I last saw the deceased alive on 2-7 1949, and that death occurred at 3:45 A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Paul Young M. D.	West Balto Gen. Hosp	2/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/10/49	Woodlawn Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	Dorothy [illegible] Williams, M.D.	E. B. Hubbard's Son	1300 Eutaw Place

VS 150 1949

927

G71359 ✓ 420.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No. G71359

1. NAME OF DECEASED (Type or Print) Caspar Prediger

2. DATE OF DEATH Feb 6 - 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2674 Dulaney St
c. Length of stay in Baltimore Yrs. Mos. Days 20 0

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 2674 Dulaney St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If years, last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	9-29-1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Germany	U.S.A.

13. FATHER'S NAME ? Prediger

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Brothers-Theodore-2674 Dulaney

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mons
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) none
DUE TO
(C) acute uremia — days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/1, 19 49 *to* 2/6, 19 49 *that I last saw the deceased alive on* 2-6, 1949 *and that death occurred at* 10:20 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Miller, M. D.	2530 Wilkens Ave	2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/10/49	Loudon Park	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	Acting for Williams, M.D.	J. B. Shipley & Son	1700 Eutaw

VS 150

93D 17

G71360 ✓ 475 G71360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 48-10168 Registered No.

1. NAME OF DECEASED (Type or Print): MARY LOU TAYLOR

2. DATE OF DEATH: February 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3659 Federal Street 26-44

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored		5/15/48		8			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balt Md	

13. FATHER'S NAME: Robert Taylor

14. MOTHER'S MAIDEN NAME: Bernie Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Berna Jackson	336 E. Federal St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Upper Respiratory Infection — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
Emil Beyer M.D.		2-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mt Calvary Cem		B. A. Co, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	Huntington Hollins	David L Brown & Son	1048 W Mulberry St

VS 151

104a

G71361 BALTIMORE CITY HEALTH DEPARTMENT 351 G71361

BIRTH NO. B.C.H-80203 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): Fred Fuller

2. DATE OF DEATH: Feb 6, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 616 E Pacca St. - 22-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Negro		6/19/1947		19			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child		Balto Md	

13. FATHER'S NAME: Jack K. Miller
14. MOTHER'S MAIDEN NAME: Rosetta Felder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(B) [illegible]
DUE TO
(C) [illegible]

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 5 1949 *to* Feb 6, 1949 *that I last saw the deceased alive on* Feb. 5, 1949 *and that death occurred at* 11a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
a. c. Fong M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/8/49	Mt Auburn	Balto City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	Finette for Williams	D. L. Brown Son	108 W Montgomery

VS 150

157D

671362 ✓ 420.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No. 671362

1. NAME OF DECEASED (Type or Print): Gertrude A. Porter

2. DATE OF DEATH: Feby. 7. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 528 E. 30th. St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 6 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE St. Michaels Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.
d. STREET ADDRESS (If rural, give location) 528 E. 30 th St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
female	white	widow	May 15, 1878	70	9 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? Talbott

13. FATHER'S NAME Jesse Dobson

14. MOTHER'S MAIDEN NAME undnown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mary A. Pratt ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial infarction — DUE TO — Interval between onset and death: 1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease — DUE TO — ?

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February 6, 1949 *to* February 7, 1949 *that I last saw the deceased alive on* Feb 6, 1949 *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Marion Sheeder M. D.

23B. ADDRESS 1737 E. North Ave.

23C. DATE SIGNED 2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE 2/10/49

24C. NAME OF CEMETERY OR CREMATORY Mt. Olive St. Michals

24D. LOCATION (City, town, or county) Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR FEB 8 1949

REGISTRAR'S SIGNATURE Thomas for Williams M.D.

25. FUNERAL DIRECTOR John O. Mitchell & Sons ADDRESS 1900 Eutaw Place

John O. Mitchell

VS 150

937

G71363 ✓ 154 G71363

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Dr. Wilbeck Francis Noville
2. DATE OF DEATH: Feb. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 601 N. Carrollton Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 44 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 601 N. Carrollton Ave. 16-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	12/24/1884	64	2 / 12	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Physician		Barbados, B.W.I.	U.S.A.

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No		Mrs. Edia C. M. Noville 601 N. Carrollton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hepatic Metastasis--Carcinoma	6 Months
DUE TO (B)	Cancer of rectom(postoperative	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	9 months ago)	
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
June 1948-J.H.H.	Cancer of Rectom--Removed	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/10/48, 19__, *to* Feb. 6, 1949 *that I last saw the deceased alive on* Feb. 6, 1949, *and that death occurred at* 9 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George McDonald M.D.	844 N. Carey St. Balt. Md.	2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/9/1949	Arbutus Memorial Pk.	Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 8 1949	Christine Williams	Mrs. George H. Holland 1631 Druid Hill Ave.

VS 150

467

G71364 ✓002 G71364

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frances Porwolskin

2. DATE OF DEATH: 2-6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1423 Hull St.
c. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE
B. COUNTY 1423 Hull St. 2 4 C 1
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Married	Apr. 14.	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife		Balto. Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Nagel	Barbara Prell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Richard F. Porwolskin 1423 Hull St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 6, 1946, *to* Feb 6, 1949, *that I last saw the deceased alive on* Feb 5, 1949, *and that death occurred at* 3 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edgar Stevens M. D.	2918 Longford Rd	2-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-9-1949	Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 8 1949	Thomas for Williams M.D.	Flynn & Fleming 1426 Light St.

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G71365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1

G71365

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Carl C. Ruhl

2. DATE OF DEATH: 2/6/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D. O. A. West Baltimore Gen'l Hospital

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 306 Lyndhurst St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	W	Married	May 26, 1897	51	8	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor	Own Business	Balto. Md.	

13. FATHER'S NAME: Conrad Ruhl

14. MOTHER'S MAIDEN NAME: Emma C. Metz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT (wife) ADDRESS: Mrs. Mildred Ruhl, 306 Lyndhurst St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Disease	
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: C. J. Sulkowski M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 2/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 10/49	Oak Lawn	Essex, Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 8 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Harry F. Witzke ADDRESS: 4101 Edmondson Ave

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671366 JL-126488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

776 671366

Registered No.

BIRTH NO. BC 49-01859

1. NAME OF DECEASED (Type or Print): Baby Boy Brown- Irene

2. DATE OF DEATH: Feb. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 3 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1424 Rutter St. 14-1

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan. 30, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months | Days: 3 | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rufus Rudd
14. MOTHER'S MAIDEN NAME: Irene Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: B. C. H. Records, ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO

ANTECEDENT CAUSES

(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ Yes ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 30, 19 49 *to* Feb. 2, 19 49 *that I last saw the deceased alive on* Feb. 2, 19 49 *and that death occurred at* 8.30A *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: B. C. H., 4940, Eastern Ave.
23C. DATE SIGNED: Feb. 3, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated
24B. DATE: 9 am. Feb. 3, 1949
24C. NAME OF CEMETERY OR CREMATORY: Balto. City Hosp. Crematory
24D. LOCATION (City, town, or county) (State): 4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 8 1949
REGISTRAR'S SIGNATURE: Evelyn [illegible]
25. FUNERAL DIRECTOR'S ADDRESS:

VS 150

159

✓ X 761.5

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71367 — BIRTH NO. B.C.49-02435 — Registered No. G71367

1. NAME OF DECEASED (Type or Print): BABY BOY PIERCE
2. DATE OF DEATH: 2-6-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — UNION MEMORIAL HOSP
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
c. Length of stay in Baltimore: hrs 6

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Sparrows Point
D. STREET ADDRESS (If rural, give location): 820 E Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
M	W		2-5-49	4 hrs 46 min.		6 hrs 14

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—			

13. FATHER'S NAME: Allen Pierce
14. MOTHER'S MAIDEN NAME: Margaret Elizabeth Orton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	—	—	Father	820 E St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Atelectasis, Bilat. Congenital	
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	28 weeks gestation	
DUE TO		
(C)	Partial premature sep. of placenta.	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
0	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
0 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 2-5-49 *to* 2-6-49, *that I last saw the deceased alive on* 2-6-49, *and that death occurred at* 1:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred Maccabe M. D.	Union Memorial Hospital	2-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
cremated	2-7-49	UMH	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	Planting for Williams, M.D.		

VS 150

160c

G71368 ✓ 420.1 G71368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John R. Schugard

2. DATE OF DEATH: 2/6/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Maryland; B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1927 W. Baltimore St.

E. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1927 W. Baltimore St.

c. Length of stay in Baltimore: 74 yrs. (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	12/25/1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): manager

10B. KIND OF BUSINESS OR INDUSTRY: Royal Lunch Room

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Genevieve Reuling ADDRESS 1927 W Baltimore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO

(B) Coronary occlusion

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from Jan 7, 1946 to Feb 6, 1949, that I last saw the deceased alive on 2-6-, 1949, and that death occurred at 11 P. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hans B. Schreiber M. D.	54 S. Fulton Ave.	2-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/10/49	New Cathedral	4300 Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	[illegible]	John J. Cowan & Son	98 Collins St

VS 150

94a

G71369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

501.4 421.4

Registered No. G71369

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mamie E. Adams

2. DATE OF DEATH 2-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2408 Madison Ave.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 2408 Madison Ave 13-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col.	Widow	Aug. 18, 1880	68		

10A. USUAL OCCUPATION (Give kind of work, even during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Eatonsville Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Andrew Sugars	Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Ernestine Watkins	2408 Mad. Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Bronchitis — 2 mo.

DUE TO

(C) —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 16, 1945, *to* Feb 4, 1949, *that I last saw the deceased alive on* Jan 29, 1949, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Douglas Shepherd M. D.	404 N. Fulton Ave	2/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-9-49	New Cathedral Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	Huntington Williams, M.D.	Mrs Katie R. Williams	922 N Schroeder St

927

G71370 VS-126197

420.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71370

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mabel Smith

2. DATE OF DEATH: Feb. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTO. CITY HOSPITALS

c. Length of stay in Baltimore: 44 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 709 Carrolton Ave. 16 C 1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
FEMALE	COLORED	SINGLE	Feb. 4, 1904	45 44				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	U.S.

13. FATHER'S NAME: James Gross

14. MOTHER'S MAIDEN NAME: Mary Short

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		RECORDS*BALTO. CITY HOSP.	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Pulmonary Infarcts and — INTERVAL BETWEEN ONSET AND DEATH: 1wk.
DUE TO thrombosis left pulmonary artery.

(B) Intramural thrombus left ventricle
DUE TO

(C) Coronary and generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-19, 1949, *to* 2-4, 1949, *that I last saw the deceased alive on* 2-4, 1949, *and that death occurred at* 9:10 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. L. Dogg M. D.	4940 EASTERN AVENUE	2-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-9-49	W. Lutheran	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
2-9-49	Huntington Williams M.D.	Mrs Katie R. Williams	Schroeder St

VS 150

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G71371

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 363.2 029 G71371

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Batty

2. DATE OF DEATH: Feb 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission): a. STATE Baltimore

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): 820 Vine St

c. Length of stay in Baltimore: all life (Yrs. Mos. Days)

d. STREET ADDRESS (If rural, give location): 18 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	C	married	Feb	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Baltimore Md	

13. FATHER'S NAME: Joseph Batty

14. MOTHER'S MAIDEN NAME: Lillie Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT: Chas Batty. ADDRESS: 522 Hoffman St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uraemia & Epileptiform — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Syphilis — ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
	//	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-4, 1949, *to* 2-6, 1949, *that I last saw the deceased alive on* 2-6, 1949 *and that death occurred at* 5:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Atwell Jones M. D.	554 Dolphin St	2-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-10-49	Pleasant Rest	Towson Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	Timothy F. Williams M.D.	Mrs Kate R Williams	322 N. Schroeder St.

VS 150

309

G71372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 G71372

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Rose Smith

2. DATE OF DEATH: Feb 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland University Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18
D. STREET ADDRESS (If rural, give location): 1015 W. Saratoga St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	C	Divorced	August 15, 1899	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Warrenton, Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Brown.

14. MOTHER'S MAIDEN NAME: Emma ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Juanita Bates. ADDRESS: 166 Chestnut St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension — 5 years

DUE TO

(C) Arteriosclerosis — 5 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 31, 1949 *to* Feb 6, 1949 *that I last saw the deceased alive on* Feb 6, 1949 *and that death occurred at* 5.25 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert C. Hunter, M.D.

23B. ADDRESS: Univ. Hospital

23C. DATE SIGNED: 2-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-10-49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

24D. LOCATION (City, town, or county): Balto. (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 8 1949

REGISTRAR'S SIGNATURE: Printing for Williams M.D.

25. FUNERAL DIRECTOR: Mrs Katie R. Williams

ADDRESS: 322 E. Schroeder St.

VS 150

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G71373

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 602 G71373

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen Johnson

2. DATE OF DEATH: Feb. 6 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital.

c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1713 W. Franklin St. 19-01

5. SEX	6. COLOR OR RACE	7 ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	negro.	Married.	May 8 1914	34		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	Maryland.	

13. FATHER'S NAME: Willie Smith

14. MOTHER'S MAIDEN NAME: Annie Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
unknown	?	Sister	1713 W Franklin St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) septicemia and shock — INTERVAL BETWEEN ONSET AND DEATH: 1-2 days?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pyelonephritis - pyonephrosis — ?

DUE TO

(C) Renal and ureteral calculus

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-4 (Hospitalized) *, 1949, to* 2-6 *, 1949, that I last saw the deceased alive on* 2-6 *, 1949, and that death occurred at* 1:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J Patterson Mack M. D.	University Hospital	2-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-9-49	Mt. Auburn Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	Mrs. Williams, M.D.	Mrs Katie R. Williams	3224 Schroeder St

VS 150

134a

G71374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

491 260 G71374

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KATIE NELSON JOHNS

2. DATE OF DEATH: February 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1112 Etting Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1112 Etting Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	colored	married	November 4, 1897	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
cook		Baltimore, Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Nelson	Emma Woods

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Bessie Williams	1112 Etting Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchopneumonia	
DUE TO		
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Diabetes mellitus	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
M.D.		Feb. 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-11-49	Arbutus Memorial Pk.	Arbutus Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	Mrs. Katie R. Williams	Mrs Katie R. Williams	3224 Schroeder Ave

VS 151

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G71375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

539.1 576 | G71375 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clyde Hayes.

2. DATE OF DEATH 2-5-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland University
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 647 W. Mulberry St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) Md.

c. Length of stay in Baltimore 10 years. Yrs. Mos. Days 4 0 2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 year: Months Days	If Under 24 Hours: Hours Min.
Male	C	Single	Oct. 5, 1915.	33	4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Jefferson, Ga.	U.S.A.

13. FATHER'S NAME Frannie Hayes

14. MOTHER'S MAIDEN NAME Mahulda Brooks.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Sallie Spencer.	647 W. Mulberry

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mediastinitis.
DUE TO Perforation of
(B) Oesophagus. Following
DUE TO Dilatation.
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
2-1-49	Generalized Peritonitis.	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-1-49, 19__, *to* 2-5-49, 19__, *that I last saw the deceased alive on* 2-5-49, 19__ *and that death occurred at* 5:35 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Hryhlower M. D.	University Hosp.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Shipped	2-9-49	Jefferson Ga.	Ga.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Funeral Director Williams	Mrs Katie P. Williams	3224 Edmondson Ave

VS 150

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BIRTH NO. 71376

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

322 Registered No. G71376

1. NAME OF DECEASED (Type or Print): JAMES SEDGEWICK

2. DATE OF DEATH: February 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Cecil
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chase
D STREET ADDRESS (If rural, give location): Eastern Ave Chase Md

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	Single	Feb. 4, 1924	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Sedgewick
14. MOTHER'S MAIDEN NAME: Mary Emma Pitts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): World War 2.
16. SOCIAL SECURITY NO.:
17. INFORMANT: Emma Sedgewick ADDRESS: Chase Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute alcoholism	
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Feb. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	Feb 9/49	Shamy St Cem.	Chase Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 8 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Mc Goff & Eckes ADDRESS: Dundalk 1129 N. Caroline St

VS 151

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AB-124310
G71377

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

193 G71377
Registered No.

1. NAME OF DECEASED (Type or Print) John A. Loeffelholtz

2. DATE OF DEATH Feb. 7- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 862 Lemmon Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	Married	Feb. 18-1905	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.

13. FATHER'S NAME Robert Loeffelholtz

14. MOTHER'S MAIDEN NAME Christiana Handel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Baltimore City Hospitals Records- ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Bronchopneumonia	2 wks.
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Brain tumor-Rt. fronto-tempro-parietal region- Glioma	1yr.
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
11-20-1948	Brain Tumor removal	YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-4- , 1948 *to* 2-7- , 1949, *that I last saw the deceased alive on* 2-7- , 1949, *and that death occurred at* 12.45PM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.		

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-10-49	New Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 8 1949	Hunting for Williams, M.D.	George L. Schwab	2101 Frederick Ave.

VS 150

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671378 ✓ 443 671378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Blitz

2. DATE OF DEATH: February 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3902 Hilton Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3902 Hilton Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Widower	1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Russia	

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr Ted Lee	3902 Hilton Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MASSIVE CEREBRAL Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive - Arteriosclerotic CVHD -

DUE TO

(C) CEREBRAL Hemorrhage, old, left.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JUNE 1947 *to* FEB 8 1949, *that I last saw the deceased alive on* FEB 8, 1949, *and that death occurred at* 6:40 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leillard Applefeldt M. D.	2511 Reisterstown Rd	2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Feb 9/49	New York City	New York City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Thomas for Williams, M.D.	Sol Levinson & Bro W Nat Ave	1126

VS 150

93D

71579 ✓ 422.2 G71579

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): **Edward Weideman**

2. DATE OF DEATH: **February 8, 1949**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **Baltimore, Maryland**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): **1728 N. Charles Street**
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): **Baltimore**
D. STREET ADDRESS (If rural, give location): **1728 N. Charles Street** 1-2-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Married	May 4, 1891	57	9	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
painter	Frank C. Long & Son	Pennsylvania	

13. FATHER'S NAME: **Edward Weideman**

14. MOTHER'S MAIDEN NAME: **?**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—			Mrs. Marie Weideman	1728 N. Charles St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac dilatation — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Myocardial failure — DUE TO — 1 year

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/1, 1946 *to* 2/7, 1949 *that I last saw the deceased alive on* 2/7, 1949 *and that death occurred at* 7a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. C. Feldman M. D.	1440 E Balto st	2/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	2/9/49	Greenville	Greenville, North Carolina

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Huntington Williams M.D.	Wm. Cook, Inc.,	1217 St. Paul Street - 2

VS 150

93E

1580 ✓ X 671580

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RICHARD CORLESS

2. DATE OF DEATH 08 FEB 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE MARYLAND B COUNTY Anne Arundel
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) FERNDALE
D STREET ADDRESS (If rural, give location) 101 ANNAPOLIS BLVD.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN. HOSP

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
MALE	WHITE	MARRIED	21 NOV 1893	55	2 17	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NIGHT WATCHMAN	Bricks	PENNSYLVANIA	

13. FATHER'S NAME: HARRY CORLESS (STEP-FATHER)

14. MOTHER'S MAIDEN NAME: EMMA TALBERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	W.W. #1		WIFE - MARY	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MASSIVE GASTROINTESTINAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 28 hours

DUE TO

(B) RUPTURED ESOPHAGEAL VARICES — 28 hours

DUE TO

(C) PORTAL CIRRHOSIS — ??

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7 FEB, 1949, *to* 8 FEB, 1949, *that I last saw the deceased alive on* 8 FEB, 1949, *and that death occurred at* 6 45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald F. England M.D.	Maryland Gen. Hosp.	8 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/10/49	Parkwood	Parkville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Evelyn L. Williams M.D.	[illegible]	[illegible]

VS 150

124 B

G71-81 ✓E983.5 N99L G71-81

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): UNKNOWN Col Infant

2. DATE OF DEATH: January 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: UNKNOWN
B. COUNTY: 17-02
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Found alley Rear 1201-05 Division
D. STREET ADDRESS (If rural, give location): UNKNOWN

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored		1-28-49			10?

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNKNOWN		U N K N O W N	

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N			N	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		INTERVAL BETWEEN ONSET AND DEATH
I	(A) Strangulation	
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
II	(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Found: Alley rear of 1201-05 Division St,	Found: Alley rear of 1201-1205 Division Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Found: 1-28-49 12:35 P. m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Strangulation(silk cord around neck)

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Carl Boyer M.D	[X] / [ ]	1-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	FEB 8 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 151

168

G71:82 ✓416 G71:82

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CATHERINE MACK

2. DATE OF DEATH: January 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

C. Length of stay in Baltimore: Yrs. _____ Mos. _____ Days _____

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 607 Archer Street 1-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C		Unknown	35				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Unknown	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown		Unknown	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Heart Failure

DUE TO

(B) _____

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Rheumatic Heart Disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		Autopsy

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
Carl L. Rogers M.D.		January 31, '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	FEB 8 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Huntington Williams M.D.	Commissioner of Health	

VS 151

95B

G71:83 420.1 G71:83

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHAIM PAPIRMEISTER

2. DATE OF DEATH 2-8-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2630 Oswego Ave

C. Length of stay in Baltimore 10 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2630 Oswego Ave

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 67 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Latvia | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Moses

14. MOTHER'S MAIDEN NAME Ida

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO

17. INFORMANT Marie Papirmeister ADDRESS 2630 Oswego Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 3 days
DUE TO Coronary artery sclerosis
(B) Coronary thrombosis — 4 yrs
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1949 19 *to* 2/8 19 49 *that I last saw the deceased alive on* 2/8/49 19 *and that death occurred at* 1130 P *m., from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M. D. | 23B. ADDRESS [illegible] | 23C. DATE SIGNED 2/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2-9-49 | 24C. NAME OF CEMETERY OR CREMATORY Adas Israel | 24D. LOCATION (City, town, or county) Balto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 9 1949 | REGISTRAR'S SIGNATURE [illegible] for Williams, M.D. | 25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eastern Ave

VS 150

94a

G71:84 ✓ 420.1 G71:84

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM L. ELLIOTT

2. DATE OF DEATH: Feb. 8th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3714 Northern Parkway
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 3714 Northern Parkway 27-05

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If Years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Sept. 18th, 1894	54	4	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Proof reader	News Post	N.Y.	U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	World War #1	216-16-3061		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary sclerosis — 6 years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct. 18, 1948 *to* Feb. 8, 1949 *that I last saw the deceased alive on* Feb 3, 1949 *and that death occurred at* 1250 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Adam Sherrio M. D.	6232 Belair Rd	Feb. 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
cremation	2/10/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Huntington Williams M.D.	Lazarus Funeral Home	7401 Belair Rd.

VS 150

94a

CERTIFICATE CORRECTED 10-16-56 016

G71585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71585

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Agnes O. Flynn (Mary Agnes)

2. DATE OF DEATH: 2/8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

D. STREET ADDRESS (If rural, give location): 113 S. Appleton St. 18 C 3

c. Length of stay in Baltimore: 39 Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Single	1/1/1910	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	at Home	Md	

13. FATHER'S NAME: James J. Flynn

14. MOTHER'S MAIDEN NAME: Mary Agnes Donohoe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
✓	✓	✓	Mrs Mary A. Flynn	113 Appleton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia secondary to	
DUE TO (B)	Carcinoma of Rectum	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5 Feb, 1949, *to* 8 Feb, 1949, *that I last saw the deceased alive on* 8 Feb, 1949 *and that death occurred at* 5:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lawrence A. D'Elia M.D.	St. Agnes Hosp.	8 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/11/49	St Peter's Cem	1300 Moreland Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Countersigned for Williams M.D.	John J. Cowan & Son	1101 Eutaw St.

VS 150

20

671386 ✓ 433.1 671386

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Blanche Klavan

2. DATE OF DEATH: February 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3904 Ayrdale Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 3 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3904 Ayrdale Ave 5 10

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec 24, 1903
9. AGE (In years last birthday): 45 (If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Isaac Tabakin
14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Sol H Klavan ADDRESS: 3904 Ayrdale Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilatation — Interval between onset and death: 1 hr.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Auricular Fibrillation — 2 years
DUE TO

(C) Thrombotic Hemorrhoid — 3 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 5, 1949, *to* Feb 8, 1949, *that I last saw the deceased alive on* Feb 7, 1949, *and that death occurred at* 4:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Friedman M. D.
23B. ADDRESS: 404 E. North Ave
23C. DATE SIGNED: Feb 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): [redacted]
24B. DATE: Feb 9/49
24C. NAME OF CEMETERY OR CREMATORY: Newark N. J.
24D. LOCATION (City, town, or county) (State): Newark N J.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 9 1949
REGISTRAR'S SIGNATURE: (Countersigned for) Williams M.D.
25. FUNERAL DIRECTOR: Sol Levin and Bro
ADDRESS: 1126 W North ave

VS 150

95a

G71.87

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71.87

BIRTH No.

1. NAME OF DECEASED (Type or print) Spencer Jackson

2. DATE OF DEATH 2/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2012 Brunt St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2012 Brunt St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital. D.O.A.

c. Length of stay in Baltimore 50 Yrs. Mos. Days 14 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	C	Married	6/10/1879	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Butler		Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Gelrge Jackson	Susie Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No		Aurelia Jackson	2012 Brunt St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Royer M.D.		6 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 10-49	A Peters	Balto City, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Williams M.D.	Chas. H. Hopkins	572 Connecticut Ave

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY GLEAVE MITCHELL

2. DATE OF DEATH: Feb. 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4112 Marx Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4112 Marx Ave. 27-21

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female.	White	Married	June 11, 1880	68 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Manchester, England	

13. FATHER'S NAME: John Gleave

14. MOTHER'S MAIDEN NAME: Mary Stansfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	none	Mr. John Mitchell	4112 Marx Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute Cardiac Dilatation	1 hr.
DUE TO (B)	Ch. Myocarditis.	2 Years
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 1, 1948, *to* Feb 8, 1949 *that I last saw the deceased alive on* Feb 8, 1949, *and that death occurred at* 3.25 a *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. S. Harding M. D.	380 S. Belair Rd	2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/11/49	Oak Lawn Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Printing for Williams M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ALONZO LEO JONES
2. DATE OF DEATH Feb. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3118 Ferndale Ave. Baltimore, 7, Md
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, 7
D. STREET ADDRESS (If rural, give location) 3118 Ferndale Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	July 27, 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Maryland	

13. FATHER'S NAME William A. Jones
14. MOTHER'S MAIDEN NAME ~~Ella~~ Georgiana Colmary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Mrs. A. Leo Jones	3118 Ferndale Ave. 7

MEDICAL CERTIFICATION

19. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of the Bladder with Generalized Metastasis	10 years
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Congestive Heart Failure	24 hours

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1948	Carcinoma of the Bladder	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 31, 1948, *to* February 8, 1949, *that I last saw the deceased alive on* February 8, 1949, *and that death occurred at* 2:10 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Millard T. Trabord Jr. M. D.	3400 Woodbine Ave. Balto 7	2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/11/49	Greenmount Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Tuntiss for Williams M.D.	WILLIAM J. TICKNER & SONS	Balto., Md

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Mr Hollis Moore Cornwall
2. DATE OF DEATH 2-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md.
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3824 Sequoia Ave 15 10

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore 26 yrs. Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married.	Oct-8-[illegible]	69 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Supt. General	Merchant & Miner	Massachusetts	

13. FATHER'S NAME George Cornwall.
14. MOTHER'S MAIDEN NAME Mary Estel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	World War #1	215-07-5469	Mrs Emma Cornwall	Same.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Abdominal Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
(B) Carcinoma of bowel & bladder
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
2-1-49	Cancer of bowel & bladder.	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 24, 1949, *to* Feb 7, 1949, *that I last saw the deceased alive on* Feb 7, 1949, *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
[illegible] Benson Jr M. D.	[illegible]	2-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/10/49	Parkwood Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Huntington Williams M.D.	WM. J. TICKNER & SONS	Balto., Md.

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BALTIMORE CITY HEALTH DEPARTMENT 451 Registered No.

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Holbrook Leonard f Hilgartner

2. DATE OF DEATH: 2/8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: 10 dys (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 33 Edmondson Ridge Rd.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3/13/1898
9. AGE (In years last birthday): 50 (If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Statistician
10B. KIND OF BUSINESS OR INDUSTRY: Esso - Standard Oil Co.
11. BIRTHPLACE (State or foreign country): Md. (Balto.)
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George G. Hilgartner
14. MOTHER'S MAIDEN NAME: Florence M. Whelan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO: 212-09-0188
17. INFORMANT: Mrs. Phoebe E. Hilgartner ADDRESS: 33 Edmondson Ridge Rd. Catonsville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured dissecting aortic aneurysm — INTERVAL BETWEEN ONSET AND DEATH: about 7 days
DUE TO
(B) Arteriosclerotic hypertensive CVD — ? yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/29/ , 1949, to 2/5/ , 1949, *that I last saw the deceased alive on* 2/5/ , 1949, *and that death occurred at* 1:20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Herbert J. Levickas M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/11/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 9 1949
REGISTRAR'S SIGNATURE: Printing for Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Rosalee Pettiford

2. DATE OF DEATH 2/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hosp.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 401 Aisquith Street 5 61

5. SEX female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 12/1/24
9. AGE (In years last birthday) 24 If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME Amanda Hopkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Yellow Atrophy of Liver — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1, 1949, to 2/8, 1949, that I last saw the deceased alive on 2/7, 1949, and that death occurred at 2:15 A. m., from the causes and on the date stated above.

23A. SIGNATURE Bobby L. Jones M. D.
23B. ADDRESS Franklin Square Hosp
23C. DATE SIGNED 2/[illegible]

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 2-13-49
24C. NAME OF CEMETERY OR CREMATORY St. John's Cem.
24D. LOCATION (City, town, or county, state) Camden 21 [illegible]

DATE RECEIVED BY LOCAL REGISTRAR FEB 9 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR Thos. S. Wilson
ADDRESS 1000 Bentley ave

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BALTIMORE CITY HEALTH DEPARTMENT 331 G71893

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Herbert Foster Griffin | 2. DATE OF DEATH: Feb 7-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3909 White Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE: Md. b. COUNTY: —

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): (at home)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 3909 White Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Widower	Aug 17 66	82-3-26				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	P.R.R.	Bello. Md.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edwin A Griffin	Mariah Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		H. F. Griffin	(Before death) Same City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Senility

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 5 1949 *to* Feb 7 1949, *that I last saw the deceased alive on* Feb 6 1949, *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. H. Pearce M. D.	2105 N. Charles St	Feb 8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-10-49	Sherwood	Cockeysville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
2/9/49	Huntington Williams, M.D.	Stewart Mortuary	Bello

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MR. GEORGE ARCHIBALD COULTER
2. DATE OF DEATH: 2-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union memorial Hospital
c. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1[illegible] [illegible] 14[illegible]

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	3-15-1877	71 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Archibald Barksdale Coulter
14. MOTHER'S MAIDEN NAME: Helen Louisa Payne Coulter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Wife — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary sclerosis — DUE TO

(B) Arteriosclerotic heart disease. — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Tumors of liver

INTERVAL BETWEEN ONSET AND DEATH: (A) 4 hrs; (B) ?; (C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-8, 1949, *to* 2-8, 1949, *that I last saw the deceased alive on* 2-8, 1949, *and that death occurred at* 7:57 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. Lewis Shaw, M. D.
23B. ADDRESS: Union Mem Hosp
23C. DATE SIGNED: 2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-10-49
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Edward Manno - Balto.

VS 150

124B

G71395

BALTIMORE CITY HEALTH DEPARTMENT 422.1 G71395

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Rosa Langhirt

2. DATE OF DEATH: Feb. 9-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1607 Eareckson

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 7-5

c. Length of stay in Baltimore: 70 Yrs. Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1607 Eareckson Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F.	W.	Widowed	July 30 1866	82	6	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Germany	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
S ? Hartman	?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	William J. Langhirt	1607 Eareckson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Chronic Myocarditis	5 yrs
	DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	Arterio-Sclerosis	10 yrs
	DUE TO		
	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 10, 1949, *to* Feb 7, 1949, *that I last saw the deceased alive on* Feb 7, 1949, *and that death occurred at* 2-30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. Gill Hall M. D.	1631 E. North ave	Feb 7 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	FEB 12 1949	HOLY REDEEMER	4430 BELAIR ROAD MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	Municipal Registrar	Doffel Bros	1806 LOMBARD ST

VS 150

937

422.1 G71396

G71396

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Francis Kopanski

2. DATE OF DEATH: Feb. 5 / 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged Poor

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1200 Valley St 10 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W.	W.	March 9, 1862	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Germany	

13. FATHER'S NAME: Jacob Kaeski

14. MOTHER'S MAIDEN NAME: Barbara —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Sister Ignatius ADDRESS 1200 Valley St Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

(B) Arteio Sclerosis — 10 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 1 1949 *to* Feb 8 1949, *that I last saw the deceased alive on* Feb 7 1949, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E Gill Hall M. D.	1631 E North Ave	Feb 8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Feb 11/49	Sacred Heart	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Mary Williams, M.D.	Rita Wendefeld	906 E. Biddle

937

G71397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

442 G71397

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRY M. BERG

2. DATE OF DEATH: 2-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2810 Ulman Avenue

c. Length of stay in Baltimore: 8 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2810 Ulman Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	March 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Real Estate Salesman		Philadelphia, Pa.	USA.

13. FATHER'S NAME: Samuel Berg

14. MOTHER'S MAIDEN NAME: Rose Rosenbaum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes World War 1	161-14-7222	Rae F Berg	2810 Ulman Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	?
DUE TO (B)	Renal Sclerosis	?
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Hypertensive arteriosclerotic	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Cardiovascular disease	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-8-49, 19__, *to* 2-8, 1949 *that I last saw the deceased alive on* 2-8, 1949 *and that death occurred at* 11:40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lisa C. Brown M. D.	W. Balto Gen'l Hosp	2-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	2-10-49	Mt. Sharon	Springfield County, Pa.

DATE RECEIVED BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Municipal Registrar John Williamson M.D.	S. Levinson & Bros.	1126 W. North Ave.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

776 G71398

BIRTH NO. G71398 BC. 49-02492 Registered No. G71398

1. NAME OF DECEASED (Type or Print) Joseph E. Schmidt Jr. | 2. DATE OF DEATH February 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore: Yrs. Mos. 2 Days

D. STREET ADDRESS (If rural, give location) 5065 Kenwood Ave. 1-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Child	2-5-49		3	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Joseph Schmidt

14. MOTHER'S MAIDEN NAME: Betty Bowman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-5 *, 19*49 *to* 2-8 *, 19*49 *that I last saw the deceased alive on* 2-8 *, 19*49 *, and that death occurred at* 7:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
H A Harrison	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/8/49	Holy Redeemer Cemetery	4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 9 1949	Cynthia Lee Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153 **Registered No.**

BIRTH NO.

1. NAME OF DECEASED (Type or Print): VIOLA B. BURKE

2. DATE OF DEATH: Feb 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. 7 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): Lombard & Greene

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct 11-1895
9. AGE (In years last birthday): 53
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Nicholas J Runaman RINAMAN
14. MOTHER'S MAIDEN NAME: Charlotte Wilhelm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO
17. INFORMANT: Joseph T. Burke ADDRESS: Hampstead Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PULMONARY EMBOLISM — Interval between onset and death: 4 hr(s).
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) CARCINOMA OF CECUM — ?

19A. DATE OF OPERATION: 1/29/49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of cecum
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 1, 1949 *to* Feb 7, 1949 *that I last saw the deceased alive on* Feb 7, 1949 *and that death occurred at* 4:37 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: David Auld M. D.
23B. ADDRESS: University Hosp
23C. DATE SIGNED: Feb 7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-10/49
24C. NAME OF CEMETERY OR CREMATORY: Hampstead
24D. LOCATION (City, town, or county) (State): Carroll Co Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 9 1949 VS 150
REGISTRAR'S SIGNATURE: Carrington Williams M.D.
25. FUNERAL DIRECTOR: Edw C. Tipton ADDRESS: Hampstead Md

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

002 Registered No. G71400

BIRTH NO. G71400

1. NAME OF DECEASED (Type or Print): Edgar J. Washington

2. DATE OF DEATH: 2-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 607 Pennsylvania Ave. 17 1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	C	Married	7/27/07	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Messinger		Washington D.C.	USA

13. FATHER'S NAME: John Washington

14. MOTHER'S MAIDEN NAME: Lottie Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Martha Washington ADDRESS: 607 Penns. Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Carl L. Rozen M.D.		2-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	1/12/49	Mt. Auburn	Balto. City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Huntington Williams, M.D.	Wm. A. Jackson	916 Penna. Ave.

VS 151

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G71401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 812.7 N703.2 G71401

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FREDERICK W. DOVER

2. DATE OF DEATH: February 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1930 Perlman Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	Mar 10th 1883	65 66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Boiler Maker		Md	

13. FATHER'S NAME: Jacob Dover

14. MOTHER'S MAIDEN NAME: Mary Burman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS: Mrs Dover 1930 Perlman Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Contusion of brain

due to Fractured skull

Intracranial hemorrhage

on Bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street--public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): North & Patterson Park Avenues

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): F 1-22-49 9:30 p. m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Pedestrian struck by bus

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 2-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 12th 1949	Morelands	Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR: FEB 9 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR ADDRESS: Leo S. Leo 1703 N. Patterson Park ave

VS 151

170 c

G71402 ✓ 420.1 G71402

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis Boisgontier

2. DATE OF DEATH: 2-5-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Colmar-French Steamer

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pier 7--Port Covington

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
32 Rue Du Docteur Fauvel-Le Havre
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): France
D STREET ADDRESS (If rural, give location): 24-4

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8 DATE OF BIRTH: Sept. 1st, 1896
9. AGE (In years last birthday): 52
If Under 1 Year: Months 5 Days 5
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ass. Cook on Ship
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Notre Dame Du Touchet Calvados France
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: George Giullon
ADDRESS: Ship Captian

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Emil L Beyer M.D.
23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 6 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: February 10/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Old Frederick Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Frank Dellacase
ADDRESS: 322 S. High St.

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M N. 126682

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71403

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Minnie Webster

2. DATE OF DEATH: Feb 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave. Baltimore City Hospitals
c. Length of stay in Baltimore: 58 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 309 Mason CT. zone 31

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED OR DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F.	W.	Sep.	June 16, 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore County	

13. FATHER'S NAME: (DEC)

14. MOTHER'S MAIDEN NAME: (DEC.)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			B.C.H. Records	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic Heart Disease — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES Yes NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-7-49, 19__, *to* 2-7, 1949, *that I last saw the deceased alive on* Feb. 7, 1949, *and that death occurred at* 5.20 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. L. Rogers M. D.	Baltimore City Hospital.	Feb. 8, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 10 1949	Loudon Park	Frederick Rd Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Huntington Williams M.D.	John J. Duda	2029 Hudson Ln

95B

G71404 ✓ 492 G71404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Samuel M. Irwin

2. DATE OF DEATH: Feb. 8/49.

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4120 Edmondson Ave.

c. Length of stay in Baltimore: 30 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4120 Edmondson Ave. 10-48

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Dec. 20, 1875	73	1	18

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman		Pennsylvania	

13. FATHER'S NAME: William Taylor Irwin

14. MOTHER'S MAIDEN NAME: Esther Ann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT: wife — ADDRESS: Texanna Irwin, 4120 Edmondson Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Card'o-Vascular-renal disease — INTERVAL BETWEEN ONSET AND DEATH: d K.

DUE TO

(B) Uremia.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Accident July 1948.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Contusions + fractures

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
July 48	Highway	Highway near Balto.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 11th 1948 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	car accident

22. *I hereby certify that I attended the deceased from* 7-16, 1948 *to* 2-7, 1949, *that I last saw the deceased alive on* 2-7, 1949, *and that death occurred at* 10 30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. W. Wilkes M. D.	3921 Edmondson Ave.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Feb. 10/49.		Portsmouth, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Huntington Williams, M.D.	Harry H. Nuttycombe	4101 Edmondson Ave.

VS 150

131a

G71405 BALTIMORE CITY HEALTH DEPARTMENT G71405

CERTIFICATE OF DEATH

Registered No. 155

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frank Albert Roberts (Born: Elmer Ellsworth HAWKINS)

2. DATE OF DEATH: February 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U S Marine Hospital
c. Length of stay in Baltimore: 29 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New Jersey
B. COUNTY: Burlington
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maple Shade
D. STREET ADDRESS (If rural, give location): 301 W. Center Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
m	W	married	Feb. 13, 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
fireman	seafarer	Wilmington, Del.	U.S.A.

13. FATHER'S NAME: James A. Hawkins

14. MOTHER'S MAIDEN NAME: Mae E. Whittier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
yes	WW I	717-09-4981	Records, U. S. Marine Hospital	Baltimore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of liver with tumor thrombosis of portal vein	Unknown
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO	Hemochromatosis with cirrhosis	Unknown
(C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 11, 1949, *to* February 9, 1949 *that I last saw the deceased alive on* February 9, 1949, *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, M. D.	U. S. Marine Hospital, Balto.	Feb. 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
REMOVAL	2/9/49	MAPLE SHADE	NEW JERSEY

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Huntington Williams, M.D.	Wm Cook Inc	1217 St Paul St

VS 150

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G71406 Grave #4. 422.2 G71406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): UNKNOWN

2. DATE OF DEATH: January 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: UNK
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Found UNK Vacant House
D. STREET ADDRESS (If rural, give location): 920 MADISON ST. 10-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) Months Days	If Under 24 Hours Hours Min.
Male	Colored			60 (?)	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNK		UNK	

13. FATHER'S NAME: UNK

14. MOTHER'S MAIDEN NAME: UNK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
UNK		UNK

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE M.D.	23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Royer		1-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	0	PUBLIC CEMETERY	FEB 8 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 9 1949	Huntington Williams, M.D.	Commissioner of Health

VS 151

937

CERTIFICATE CORRECTED 2-18-49 ✓ 422.2

G71407

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71407 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EMMA B. TILLMAN

2. DATE OF DEATH: 2/8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1913 Eutaw Place

c. Length of stay in Baltimore: Unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write R.F.D. and give township): Baltimore
D STREET ADDRESS (If rural, give location): 5220 Ivanhoe ave.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year Months / Days	If Under 24 Hours Hours / Min.
Female	white	~~Married~~ Widowed	3/28,1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Seamstress	Government Industrial Mill	Virginia	U.S.A.

13. FATHER'S NAME: Unknown

14 MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): ---

16 SOCIAL SECURITY NO: 218-09-9746

17 INFORMANT: Mr. William H. Frock ADDRESS: 5220 Ivanhoe avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocarditis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 5 *, 1949, to* Feb 8 *, 1949, that I last saw the deceased alive on* Jan 5 *, 1949, and that death occurred at* 11 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. H. Cutterman M. D. | 23B ADDRESS: 2314 Reisterstown Rd | 23C. DATE SIGNED: 2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/10/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 9 1949

REGISTRAR'S SIGNATURE: [illegible]

25 FUNERAL DIRECTOR: Chas. J. Evans & Son. Inc. ADDRESS: 118 N. Mt. Royal Ave. 93

G71408 ✓ 420.0 G71408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis Ocello

2. DATE OF DEATH: Feb. 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5109 Linden Heights
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 8 Yers (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
5109 Linden Heights Ave 2-7-18
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore Md.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	White	Married	Aug. 17 1891	57	5 / 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	Baking	Italy	U.S.

13. FATHER'S NAME: Francesco Ocello

14. MOTHER'S MAIDEN NAME: Josephine Matticla

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 117-10-6117

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosus — INTERVAL BETWEEN ONSET AND DEATH: immediately

DUE TO

(B) arteriosclerotic heart disease — several years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Feb 8, 1949 5 P. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 25, 1948, *to* Feb. 7, 1949, *that I last saw the deceased alive on* Jan. 25, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bernard Burgin M. D.	672 Reisterstown Rd.	Feb. 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 11/1949	Calvary	Queens Co. N.Y.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Huntington Williams, M.D.	Frank Wells Sons	322 S. High St.

VS 150

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AB-41107

G71409

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

002 G71409

Registered No.

1. NAME OF DECEASED (Type or Print): Albert Bush

2. DATE OF DEATH: 1-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 36 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 28 Albermarle Street

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Divorced	Feb. 28-1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Pennsylvania	U.S.

13. FATHER'S NAME: Albert Bush

14. MOTHER'S MAIDEN NAME: Jennie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S ADDRESS: 4940 Eastern Ave. Records-Baltimore City Hospitals

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchictasis	10-12yrs.
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Pulmonary Tuberculosis	10-12 yrs.
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Uremia	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-19- , 19 39 *to* 1-31- , 19 49 *that I last saw the deceased alive on* 1-31- , 19 49 *and that death occurred at* 3.30P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. L. Hoyle M. D.	Baltimore City Hospitals	Feb. 8-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	FEB 9 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

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G71410

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

526 49 Registered No. G71410

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RUSSELL BELL

2. DATE OF DEATH February 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2440 Frederick Avenue

c. Length of stay in Baltimore Yrs. Mos. Days 1 week

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,

D. STREET ADDRESS (If rural, give location) 2440 Frederick Avenue 20 C 4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	married	May 14 1913	~~32~~ 35		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Press Operator	Revere Copper & Brass Co	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME Lewis Bell

14. MOTHER'S MAIDEN NAME Ennie Baldwin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		213-01-7218	Mary M. Bell	2440 Frederick Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bronchiectasis

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER ☒ / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George G. Merrill M.D.		2-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 10, 1949	Savage Cemetery	Savage, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 9 1949	Huntington Williams, M.D.	De Witt Donaldson	Laurel, Md.

VS 151

108

G71411 ✓ x 174 G71411

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Pahlman

2. DATE OF DEATH: 2/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY: Baltimore Co
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 28 Catonsville
D. STREET ADDRESS (If rural, give location): 719 S. Rolling Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	1/31/1906	43		7

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CASHIER	Moving Picture	Md	U.S.A.

13. FATHER'S NAME: Charles Pfeiffer

14. MOTHER'S MAIDEN NAME: Maggie Brooks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
	213-20-1223	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Carcinoma of Uterus

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10 Oct 48	Endometrium	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/9, 19 49, *to* 2/2, 19 49 *that I last saw the deceased alive on* 2 Feb, 19 49 *and that death occurred at* 11:20 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm B Elia Jr M. D.	St Agnes Hosp	2 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 10, 1949	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
FEB 9 1949	Huntington Williams M.D.	Easton Sons Catonsville Md.

VS 150

486

✓ 122.1

G71412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71412

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) **Edward G. McGee**

2. DATE OF DEATH **Feb. 8, 1949**

3. PLACE OF DEATH: A. Baltimore City, Maryland **Baltimore, Md.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **2414 St. Paul Street**

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** 1-6

D. STREET ADDRESS (If rural, give location) **2414 St. Paul Street**

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	**white**	**single**	**Nov. 11, 1886**	**62**	**2 27**	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plumber		**Baltimore, Maryland**	

13. FATHER'S NAME **Patrick F. McGee**

14. MOTHER'S MAIDEN NAME **Mary Donlan**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
NO	**216-14-772.**	**Nora McGee**	**2414 St. Paul Street**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic Cardio-Vascular Disease	1 yr.
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-1, 1949 *to* 2-8, 1949 *that I last saw the deceased alive on* 2-7, 1949, *and that death occurred at* 2:45 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. D. Flynn M. D.	11 E. Chase St	2-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	**2/11/49**	**New Cathedral**	**Baltimore, Maryland**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	Huntington Williams, M.D.	**Wm. Cook, Inc.,**	**1217 St. Paul Street**

VS 150

93D

✓ 443

G71413

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71413

Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Edna Redmond

2. DATE OF DEATH: 2-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq. Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-5
D. STREET ADDRESS (If rural, give location): 2327 Calverton Heights

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~ (Specify): Widowed
8. DATE OF BIRTH: 2-9-1904
9. AGE (In years last birthday): 44 45
If under 1 Year: Months 11 Days 29
If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housfe
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry C. Stoner
14. MOTHER'S MAIDEN NAME: Mary Adlesberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Harry C. Stoner ADDRESS: 4213 Rusape Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: hr
DUE TO
(B) Hypertensive C.V. Disease — 5 yr
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-8, 1949, *to* 2-8, 1949, *that I last saw the deceased alive on* 2-8, 1949, *and that death occurred at* 1:35 pm., *from the causes and on the date stated above.*

23A. SIGNATURE: A. J. Laham M. D.
23B. ADDRESS: Franklin Sq. Hosp
23C. DATE SIGNED: 2-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/12/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 127 St. Paul St

VS 150

93D

G71414

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153 G71414
Registered No.

1. NAME OF DECEASED (Type or Print): Irene Florence Keimig

2. DATE OF DEATH: 2/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1247 Washington Boulevard
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-2
D. STREET ADDRESS (If rural, give location): 1247 Washington Boulevard

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	married	March 28, 1898	50	0	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
hat trimmer	M.S.Levy, Men's Hats, Inc.	Baltimore, Maryland	

13. FATHER'S NAME: William Dixon

14. MOTHER'S MAIDEN NAME: Mary V. Shaw

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	215-10-0880	John F. Keimig, 1247 Washington Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		(INTERVAL BETWEEN ONSET AND DEATH)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma Large Bowel	3 mo.
DUE TO (B)		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Dec 1948	Carcinoma Large Bowel -	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5/20, 1948 *to* 2/7, 1949, *that I last saw the deceased alive on* 2/7, 1949, *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward D. Kaelin M. D.	1847 W. Mount Av	2/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/10/49	National Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 10 1949	Huntington Williams, M.D.	Wm. Cook, Inc., 1217 St. Paul Street

VS 150

46 E

G71415 401.1 G71415

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): James Cornish, Jr.

2. DATE OF DEATH: Feb. 9, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1403 Harford Ave

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: 11-5-13

9. AGE (If under 1 year, Months / Days; If under 24 hours, Hours / Min.): 35

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Cornish

14. MOTHER'S MAIDEN NAME: Marcella Aggiulla

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):

16. (If yes, give war or dates of service):

SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subacute bacterial endocarditis — INTERVAL BETWEEN ONSET AND DEATH: months.

DUE TO

(B) Rheumatic heart disease — years.

DUE TO ? type of organism.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12/31, 1948 *to* 2/9, 1949 *that I last saw the deceased alive on* 2/9, 1949 *and that death occurred at* 12:20 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE: Anthony J. Lee, M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 2-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/12/49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

24D. LOCATION (City, town, or county) (State): A. A. County, Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Joseph B. Locks, Jr. ADDRESS: 1304 N. Central Ave

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71416

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 71416

1. NAME OF DECEASED (Type or Print): Walter Edward Ridgely

2. DATE OF DEATH: February 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U. S. Marine Hospital

c. Length of stay in Baltimore: 1 day (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellicott City
D. STREET ADDRESS (If rural, give location): Columbia Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
m	w	married	Dec. 5, 1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist		Maryland	U.S.A.

13. FATHER'S NAME: Edward Ridgely

14. MOTHER'S MAIDEN NAME: Roberta Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
yes	WW I	219-10-3330	Records, U. S. Marine Hospital,	Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Congestive heart failure due to Hypertensive cardiovascular disease	1 day / 2 years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Pneumonia, broncho, terminal	1 day
(C)	Osteoarthritis, multiple	2 years
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* February 8, 1949, *to* February 9, 1949 *that I last saw the deceased alive on* February 9, 1949, *and that death occurred at* 9:25 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
John L. Wilson, M. D.	U. S. Marine Hospital, Balto	Feb. 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2-12-49	St Johns	Ellicott City Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	Huntington Williams, M.D.	F. C. Higinbotham	

VS 150

927

G71417

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

151 G71417

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Henry Burke

2. DATE OF DEATH 2/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 623 Sewell St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life 63 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-2
D. STREET ADDRESS (If rural, give location) 623 Sewell St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C			63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY Hashing

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-07-4151

17. INFORMANT Bessie B. Dorsey ADDRESS 1633 Walsh St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of stomach
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: unknown

19A. DATE OF OPERATION June 1948

19B. MAJOR FINDINGS OF OPERATION Extensive intra-abdominal metastasis

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Neither

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/16, 1948 *to* 2/8, 1949 *that I last saw the deceased alive on* 2/8, 1949 *and that death occurred at* 2:45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE O. W. Hoffler M.D. M. D.

23B. ADDRESS Provident Hosp

23C. DATE SIGNED 2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Feb 2 - 1949.

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary

24D. LOCATION (City, town, or county) (State) Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 1 0 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Va Brooks ADDRESS 1463 N. Carey St

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71418

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 71418

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary A. O'Conor

2. DATE OF DEATH: Feb 6 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1123 Valley Street 10-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	?	About 70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James O'Conor	Sarah Farrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Miss Ella O'Conor	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 Days

DUE TO

(B) arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/31/49, 19—, *to* 2/8/49, 19—, *that I last saw the deceased alive on* 2/8, 1949 *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Henry V. Chase M. D.	Mercy Hospital	2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/11/49	St. Joseph's	Texas, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	Huntington Williams M.D.	W. W. Weeks and Son	503 W. Saratoga St.

VS 150

94a

Thos. E. Grove

G71419 — 223 — G71419

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Thomas E. Grove — 2. DATE OF DEATH: 2-9-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — St Agnes Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md — B. COUNTY: Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md — 28-4
D. STREET ADDRESS (If rural, give location): 206 Mallows Hall

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	Married	6-1-1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Retired	Md.	U.S.A.

13. FATHER'S NAME: Wm H. Grove

14. MOTHER'S MAIDEN NAME: Nancy Fleming

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
NO			Hospital Record	Same.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ca supp. of med (left) — DUE TO

(B) Cholesteatoma (cholesteatoma) — DUE TO

(C) Embolic (cardiac).

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Since childhood

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Jan 20-49	Ca supp. of med - cholesteatoma	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 20 1949 *to* Feb 9, 1949 *that I last saw the deceased alive on* Feb 9, 1949 *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred H. Keyser M. D.	Medical Arts Bldg	2-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/12/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

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71420 ✓ 334 G71420

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Harriett Myers Harriett

2. DATE OF DEATH: Feb 7th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1933 N Patterson Park Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto E-2
D. STREET ADDRESS (If rural, give location): 1933 N. Patterson Park Ave

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Mar 6th 1884
9. AGE (In years last birthday): 64 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Morgan
14. MOTHER'S MAIDEN NAME: Powhatan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs Myers ADDRESS: 1933 N Patterson Park ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) right hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(B) hypertension
DUE TO
(C) arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 30 1948 *to* Feb. 7 1949, *that I last saw the deceased alive on* Feb 7, 1949, *and that death occurred at* 7.50 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: L. C Dobihal M. D.
23B. ADDRESS: 4474 Kenwood Ave.
23C. DATE SIGNED: 2/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: Feb 11th 1949
24C. NAME OF CEMETERY OR CREMATORY: Baltaleem
24D. LOCATION (City, town, or county) (State): E. North Ave Balt

DATE RECEIVED BY LOCAL REGISTRAR: FEB 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leo S. Cook ADDRESS: 1705 N. Patterson Park Ave

VS 150

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G71421
BIRTH NO.

✓ 170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71421
Registered No.

1. NAME OF DECEASED (Type or Print): MYRTLE I. BRADSHAW

2. DATE OF DEATH: 2/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland I710 Johnson Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): I710 Johnson Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	M	4/1/1891	57	10	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore	

13. FATHER'S NAME: Eugene Perkins - Md.

14. MOTHER'S MAIDEN NAME: Wilhelmina Cunningham - Md.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
NO		Family - Same	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the left breast
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1948 *to* 2/8/49, 19__, *that I last saw the deceased alive on* 2-7-49, 19__, *and that death occurred at* 130 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Denis J. McGrath M. D.	1E Randall St Balto 24	2-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	2/11/49	Glen Haven	Glen Burnie, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	Huntington Williams, M.D.	James L. McCreary	- 130 E. Fort Ave.

VS 150

50

G71422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. G71422

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELIZABETH D. BESTPITCH

2. DATE OF DEATH: 2/8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1913 Eutaw Place

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ellinger Nursing Home

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-2
D. STREET ADDRESS (If rural, give location): 404 E. Cross Street

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	W	6/19/1872	76	7 19	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME: Samuel Wilson - Maryland

14. MOTHER'S MAIDEN NAME: Annie ? - Maryland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Family - Same	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral hemorrhage	
DUE TO:		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov. 9, 1948, *to* Feb 8, 1949, *that I last saw the deceased alive on* Feb 7, 1949, *and that death occurred at* 3 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. H. Patterson M. D.	2324 Reisterstown Rd	2/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	2/11/49	Cedar Hill	Brooklyn. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	[illegible]	Jas. L. McElroy	130 E. Fort Ave.

VS 150

83a

G71423 Batchatis ✓ 443 G71423

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Rena Batchatis

2. DATE OF DEATH: Feb 8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1720 Montford

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1720 Montford ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 8-2
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	widow	Sept 23 1887	61	4 / 15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore	

13. FATHER'S NAME: August

14. MOTHER'S MAIDEN NAME: Anna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs Mildred Hudson ADDRESS: 1720 Montford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11/29, 1948 *to* 2/6, 1949 *that I last saw the deceased alive on* 2/8/49, 19___, *and that death occurred at* 4:20 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Max Bauer M. D.	1501 N. Milton Ave	2/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/11/49	Baltimore	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	Hampton Williams, MD	Ulrich Funeral Home	2408 Orleans St

VS 150

93D

G71424

Medical Examiner's Case
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 900.0 N 930.0 G71424

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Anna Strohmunger
2. DATE OF DEATH: Feb 9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 429 N Montford
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 232 N Port
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 6-3
D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	widow	Jan 16	77	/	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) Fracture, intertrochanteric, femur rt — CERTIFIED

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Stanley B. Klyanowicz M. D.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
accident.	home	232 N Port St. — 6/A

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
1 26 49 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Patient - senile - fell down stairway

22. *I hereby certify that I attended the deceased from* 3 Feb 19 49 *to* 9 Feb 19 49, *that I last saw the deceased alive on* 9 Feb 19 49, *and that death occurred at* 4:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Stanley B. Klyanowicz M. D.	1127 N. St. Paul St	9 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2/14/49	Oak Lawn	Colgate Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 10 1949	Huntington Williams M.D.	Ulmer Funeral Home - 2008 Eastern Ave

VS 150

186a

G71425 MARLIN 13M.5 451 G71425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO MARLIN-L-CASSEL Registered No.

1. NAME OF DECEASED (Type or Print): MARLIN-L-CASSEL

2. DATE OF DEATH: 2/8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME HOSPITAL

c. Length of stay in Baltimore: 10 Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 8-1

D. STREET ADDRESS (If rural, give location): 3101 MARECO AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W		Nov 3 1919	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN		Pennsylvania	

13. FATHER'S NAME: LEROY CASSEL

14. MOTHER'S MAIDEN NAME: EMMA POTTIEGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
yes	2nd War	203-10-7524		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemothorax, left — INTERVAL BETWEEN ONSET AND DEATH: 11 days

DUE TO

(B) Rupture of descending Aorta — 11 days

DUE TO coarctation of Aorta and mycotic thrombus

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-27, 1949 *to* 2/8, 1949 *that I last saw the deceased alive on* 2/8, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald W. Wintz M. D.	Church Home	2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	Feb 12-49	Baltimore	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	Municipal Williams, M.D.	Jos J. Herr & Son	3001 Eastern Ave

VS 150

96

G71426

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1 G71426

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DANIEL N. CAPOZZI

2. DATE OF DEATH: February 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: 28 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): 6302 Dunhill Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Feb-29 1903	45	11	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	Bath. Steel	Cannonburg Pa.	U.S.A.

13. FATHER'S NAME: Emilo Capozzi

14. MOTHER'S MAIDEN NAME: Louise Cavalier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: 216-10-4158

17. INFORMANT: Frances L. Capozzi ADDRESS: 6802 Dunhill Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George L. Merrill M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED: 2-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb-12-49	SACRED HEARTS CEM.	GERMAN HILL RD MD.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 10 1949

REGISTRAR'S SIGNATURE: Hunter Jr. Williams M.D.

25. FUNERAL DIRECTOR: Duffel Bros. ADDRESS: 710 BELAIR ROAD.

VS 151

94a

G71427 ✓422.1 G71427

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Jozefa Swiecz Kowski
2. DATE OF DEATH: February 8, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 1246 S Ellwood Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 1-1
D. STREET ADDRESS (If rural, give location) 1246 S Ellwood Ave
c. Length of stay in Baltimore 63 yrs. (Yrs. Mos. Days)
5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: March 10 1853
9. AGE (In years last birthday): 95 (If Under 1 Year: Months 10, Days 28; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Poland Germany
12. CITIZEN OF WHAT COUNTRY? U S A.
13. FATHER'S NAME: Frank Korda
14. MOTHER'S MAIDEN NAME: Anna Ononutry
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT: Anton W. Swiecz Kowski ADDRESS 1246 S Ellwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchio - pneumonia — (Interval between onset and death) 12 hr.
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Arterio-sclerotic cardio-vascular disease — 10 yr.
DUE TO
(C) Senility

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 11, 1949, *to* February 8, 1949, *that I last saw the deceased alive on* February 7, 1949, *and that death occurred at* 3:10 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE James W. Insley M. D.
23B. ADDRESS 936 E. Baltimore St.
23C. DATE SIGNED 2/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 2-11-49
24C. NAME OF CEMETERY OR CREMATORY Holy Cross
24D. LOCATION (City, town, or county) (State) Gorman Hill Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 10 1949
REGISTRAR'S SIGNATURE Christian Williams M.D.
25. FUNERAL DIRECTOR Pepper Bros ADDRESS 1800 E. Lombard St.

VS 150

937

G71428 ✓ 443

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71428

1. NAME OF DECEASED (Type or Print): Solomon Goldberg

2. DATE OF DEATH: Feb. 10.1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 5835 Jonquil Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5835 Jonquil Avenue

c. Length of stay in Baltimore: 60 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 5835 Jonquil Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Widower	July 4, 1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY: Tailoring

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Benjiman Goldberg

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Miss Rose Goldberg 5835 Jonquil Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic Cardio Vascular Disease with Hypertension	2½ yrs –
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) ✓	
DUE TO		
	(C) ✓	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	✓	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
✓	✓	✓

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
✓ m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	✓

22. *I hereby certify that I attended the deceased from* Summer 1946 *to* Feb 10th, 1949, *that I last saw the deceased alive on* Feb 10, 1949, *and that death occurred at* 4.30A. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Michael A. Abrams M. D.	1800 Eutaw place	Feb 10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb, 11, 1949	Hebrew Rosedale Cem	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	Thurlington Williams	S. Levinson & Bros	1124-26 W. North Ave

VS 150

93D

G71429 Anna Mullaney ✓ 2011 260 G71429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Annie T. Watson (ANNA T. WALSH)

2 DATE OF DEATH 2/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

c. Length of stay in Baltimore 40 yrs Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE Md.
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-9
D. STREET ADDRESS (If rural, give location) 901 S. Eaton Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed		70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11 BIRTHPLACE (State or foreign country) Ireland
12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thomas Walsh
14 MOTHER'S MAIDEN NAME Winifred Knockton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO —
17 INFORMANT Mrs Louisa Smith ADDRESS 901 S. Eaton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Diabetic Coma — 2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Arteriosclerosis Gen — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Purulent Pericarditis — ?

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/7 1949 *to* 2/9 1949, *that I last saw the deceased alive on* 2/9/49 19 *and that death occurred at* 8:25 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE Alex C. Bell Jr M. D.
23B ADDRESS South Balto. General Hospital
23C DATE SIGNED 2/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B DATE Feb 11 49
24C NAME OF CEMETERY OR CREMATORY New Cathedral
24D LOCATION (City, town, or county) Baltimore (State)

DATE RECEIVED BY LOCAL REGISTRAR FEB 10 1949
REGISTRAR'S SIGNATURE [illegible] Williams M.D.
25 FUNERAL DIRECTOR Phelps Heaney Sons ADDRESS 2019 Eastern Ave

VS 150

61

G71430

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

491, 54 p. 1 G71430

BIRTH NO. _____ Registered No. _____

1. NAME OF DECEASED (Type or Print): WALKER, Katherine

2. DATE OF DEATH: 2-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 7 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission):
A. STATE
B. COUNTY 1428 Division St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location)

14-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	C	S	1/5/42	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student		Balto. Md.	

13. FATHER'S NAME: James Walker

14. MOTHER'S MAIDEN NAME: Nazaebth Richardson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		James Walker	1428 Division St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema
DUE TO
(B) Cardiac Failure
DUE TO
(C) Bronchopneumonia, Bilateral

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Paralytic Ileus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2-6-49	Paralytic Ileus	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-6- 19[illegible], *to* 2-3- 19[illegible], *that I last saw the deceased alive on* 2-3, 19[illegible], *and that death occurred at* 11: A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William A. Lieuallen M. D.	University Hospital	2-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/11/49	Mt Calvary	md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	Territory for Williams, M.D.	George H. Kilron	1303 Priestman St

VS 150

122R

Dr. H.C.Hyde
71-11 1100 E. North

331
260 G71431

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Olivia B. Cummings

2. DATE OF DEATH: Feb. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3200 Evergreen Avenue

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-44
D. STREET ADDRESS (If rural, give location): 3200 Evergreen Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Jan.11,1864	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Maryland	

13. FATHER'S NAME: Samuel Burnham

14. MOTHER'S MAIDEN NAME: Lydia S. Hopkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Mrs. John Bowen, 3200 Evergreen Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		
(A) DUE TO	Cerebral Hemorrhage Right - Infarction Pontis	7 days
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO	Cerebral Arteriosclerosis Hypertension	?
(C)	Mild Diabetes	?
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 2, 1949 *to* Feb 9, 1949 *that I last saw the deceased alive on* Feb 8 1949 *and that death occurred at* 9:10 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Hyde M. D.	1100 E North Ave	2-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-11-49	Loudon Park	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 10 1949	Thurston Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

61

G71432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1 G71432

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Andrew Hinkle

2. DATE OF DEATH: Feb. 6 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3026 Fleetwood Ave.

C. Length of stay in Baltimore: 66 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: None
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 27-5
D. STREET ADDRESS (If rural, give location): 3026 Fleetwood Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) / If Under 1 Year: Months Days / If Under 24 Hours: Hours Min.
Male	White	Married	Mar 7, 1882	66

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clothing Cutter	Tailor	Baltimore Maryland	U.S.A.

13. FATHER'S NAME: William Hinkle.

14. MOTHER'S MAIDEN NAME: Margaret Bayline.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	—	214-03-5[illegible]	Helen Heimig	3026 Fleetwood.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis.	Immediate
DUE TO (B)		
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—		—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* May, 1948 *to* Jan. 28, 1949 *that I last saw the deceased alive on* Jan 28, 1949 *and that death occurred at* 12 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Osborne M. D.	5602 Harford Rd	Feb 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/11/49	Holy Redeemer	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	[illegible]	Leonard J. Luck	5305 Harford

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G71433
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

216 002 G71433
Registered No.

1. NAME OF DECEASED (Type or Print): AUGUSTA M. MACK
2. DATE OF DEATH: 2-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-1
D. STREET ADDRESS (If rural, give location): 4229 Berger Ave.

5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Feb. 4-1887
9. AGE (In years last birthday): 62 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Otto V. Kleinstein
14. MOTHER'S MAIDEN NAME: Rosalie Sunday

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT — ADDRESS: Mr. August Mack-4229 Berger

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subacute bacterial endocarditis
DUE TO
(B) Streptococcus fecalis septicemia
DUE TO Infected ovarian cystadenoma
(C) Infected draining st. lower abdominal fistula

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Pulmonary tuberculosis

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [✓] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-23-, 1949, *to* 2-9-, 1949, *that I last saw the deceased alive on* 2-9-, 1949, *and that death occurred at* 6:55 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: A Harris M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 2-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/12/49
24C. NAME OF CEMETERY OR CREMATORY: Meadowridge
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 10 1949
REGISTRAR'S SIGNATURE: Irvington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Leonard J. Luck-5305 Harford

13B

BIRTH NO. G71434

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71434

1. NAME OF DECEASED (Type or Print): Frederick Nolting

2. DATE OF DEATH: 2/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 49 S. Arlington Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 11 1887
9. AGE (In years last birthday): 61 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern Owner
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frederick Nolting
14. MOTHER'S MAIDEN NAME: Sophia Struckmeier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 217-01-6292
17. INFORMANT: Katherine K. Nolting — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Kidney c generalized metastases — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Perforation of Metastatic Lesion of Stomach — 24 hrs

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [✓] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2 17 , 1999 *to* 2/9/49 , 19 , *that I last saw the deceased alive on* 2/9 1949 *and that death occurred at* 705 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Alvin R. Gallagher M. D.
23B. ADDRESS: South Balto. Gen. Hosp.
23C. DATE SIGNED: 2/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 11 1949
24C. NAME OF CEMETERY OR CREMATORY: Meadow Ridge Memorial
24D. LOCATION (City, town, or county) (State): Wash. Blvd. Elkridge Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Frederick A. Cole
ADDRESS: 1200 W. Lombard St

VS 150

52a

G71435 ✓ +443 G71435

JL- 126336

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Getshall

2. DATE OF DEATH: Feb. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Dundalk
D. STREET ADDRESS (If rural, give location): 19 Winona Ave.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	June 29, 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home Duties		Md.	

13. FATHER'S NAME: John Saffran

14. MOTHER'S MAIDEN NAME: Elizabeth Werb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	219-18-7620	B. C. H. Records,	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid Hemorhage
DUE TO
(B) Hypertensive Cardiac Disease.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ No NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 25, 19 49 *to* Feb. 9, 19 49 *that I last saw the deceased alive on* Feb. 9, 19 49, *and that death occurred at* 8.30A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. A. Rogers M. D.	4940 Eastern Ave.	Feb. 9, 19 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/12/49	Loudon Park	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 10 1949	Huntington Williams, M.D.	Frederick A. Cole	937

VS 150

71436

✓ x 422.1
527.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71436

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry Leutner

2. DATE OF DEATH: 2-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Woodlawn
D. STREET ADDRESS (If rural, give location): 7320 Windsor Mill Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	Married		65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanical Engineer	Manufacturing	Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm. S. Leutner	Lena A. Hopkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Un Known			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~cardio~~ right sided heart failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Emphysema

DUE TO

+ arteriosclerotic CVD

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-6-, 1949, *to* 2-9-, 1949, *that I last saw the deceased alive on* 2-9-, 1949, *and that death occurred at* 7.15a m., *from the causes and on the date stated above.*

23A. SIGNATURE: John H Rosser M. D.

23B. ADDRESS: University Hospital

23C. DATE SIGNED: 2-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb. 12-49

24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Morris S. Lyffer

ADDRESS: 1600 W. North Ave.

937

71437 ✓ X422.2 G71437

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Gregory Cartwright
2. DATE OF DEATH: Feb. 10, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY Wicomico
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salisbury
c. Length of stay in Baltimore: Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 709 S. Division ST
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 9-19-48
9. AGE (In years last birthday): If Under 1 Year Months 4 Days; If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Morris Cartwright
14. MOTHER'S MAIDEN NAME: Carolyn Simpson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocarditis
DUE TO
(B) Etiology unknown
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES [X] NO [ ]
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/24 19 49 *to* 2/10 19 49, *that I last saw the deceased alive on* 2/10 19 49, *and that death occurred at* 12 25 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leopold O. Goldstein M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/12/49
24C. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial
24D. LOCATION (City, town, or county) (State): Salisbury, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: John C. Melly Inc.
ADDRESS: 2435 E. Oliver St

VS 150

161C

Dr. Krumrein 722 N. Kenwood Ave No 5966

71438 BALTIMORE CITY HEALTH DEPARTMENT 153 (71438

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dr. Alvin Hones Hewing Sr.

2. DATE OF DEATH: Feb 9th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1212 Windermere Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D STREET ADDRESS (If rural, give location): 1212 Windermere Ave 9 3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Married	1/10/1880	69	0 29	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Retired	Pharmacist	Balto.	Md.

13. FATHER'S NAME: George T. Hewing

14 MOTHER'S MAIDEN NAME: Isabelle Delcon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT
No	218-22-1238	Alvin H. Hewing Jr Res Address Rock Rd. Randallstown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Dec 13/48

DUE TO

(B) adeno-carcinoma - Sigmoid - Large bowel -

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
Dec 13/48	Resection - of Ileo - Sigmoid	YES ☐ NO ☑

21A. ACCIDENT? SUICIDE? HOMICIDE? (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 8, 1948, *to* Feb 9, 1949 *that I last saw the deceased alive on* Feb 8, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Louis H. Krumrein M. D.	722 No. Kenwood Ave	2/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/11/49	Lorraine	Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Huntington [illegible]	Wm Cook, Inc.	1217 St. Paul St.

VS 150

46E

G71439 420.1 G71439

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) SAMUEL MAISEL

2. DATE OF DEATH 2-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1814 East Fairmount Ave

c. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1814 East Fairmount Ave

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH

9. AGE (In years last birthday) 82 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Not Known

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary infarction
DUE TO
(B) Ch myocarditis
DUE TO
(C) Generalized Sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)

21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/14 1949 to 1/25, 19 49, that I last saw the deceased alive on 1/25, 19 49, and that death occurred at 8:17 m., from the causes and on the date stated above.

23A. SIGNATURE M. D.

23B ADDRESS 2042 Bridge St

23C DATE SIGNED 2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B DATE 2-11-49

24C NAME OF CEMETERY OR CREMATORY Rosedale

24D LOCATION (City, town, or county) Balto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 11 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25 FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

VS 150

9-D

G71440 ✓ 241 G71440

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Nannie Nimmo Smith

2. DATE OF DEATH: Feb 9, 49

3. PLACE OF DEATH: A. Baltimore City, Maryland. Roland Ave & Belmont Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kirkleigh Villa

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto. City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 7301 Roland Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widow	Apr 7 1863	85 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Baltimore, Md.	U. S. A.

13. FATHER'S NAME: James C. Nimmo

14. MOTHER'S MAIDEN NAME: Elizabeth Jervis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	None	Mrs. Albert Von D. Smith	Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Chronic Myocarditis	6 mos.
DUE TO (B)	Chronic Asthmatic Bronchitis	10 years.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	✓	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	✓	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	✓	YES ☐ NO ✓

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
✓	✓	✓

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
✓ m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	✓

22. *I hereby certify that I attended the deceased from* Jan. 10, 1945 *to* Feb. 9, 1949, *that I last saw the deceased alive on* Feb. 9, 1949, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank M. Ogden M.D.	2701 N. Calvert St.	Feb. 10, 49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2-11-49	Greenmount Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Huntington Williams, M.D.	Stewart & Mowen Co.	128 N. North Ave. Balto 1, Md

VS 150

D.O.A. Gloria ✓ 759.0 G71441

G71441

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 48-19445 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Gloria JEAN Gibson

2. DATE OF DEATH: February 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 1936 Christian St. 20-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Child	9-4-48		5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry R. Gibson
14. MOTHER'S MAIDEN NAME: Carmela Badolato

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Bronchopneumonia	7 days.
DUE TO (B)	Partial respiratory paralysis	3 ms.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Amyotonia Congenita, question of?	Life ?
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. , 1948, to Feb 1 , 1949 *that I last saw the deceased alive on* Feb 5 , 1949, *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: David B. Clark M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 2/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-12-49	Mt. Olivet	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: G. Howard Strong ADDRESS: 3207 W. NORTH AVE.

VS 15b

107

G71442
JL- 125264
BIRTH NO.

✓ 340.3(7) X

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71442
Registered No.

1. NAME OF DECEASED (Type or Print): Willie Wills

2. DATE OF DEATH: Feb. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Prince George
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Crownsville State Hospital. Colored (over)
D. STREET ADDRESS (If rural, give location): Crownsville State Hosp. A. A. Co.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Col.	?	Dec. 13, 1913	35 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		?	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malnutrition - Sepsis and Anemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Decubitus Ulcer Rt.&Lt hips with extensive Osteomyelitis, and spontaneous Dislocation of Rt. Hip.

DUE TO

(C) Paraplegia due to Spinal arachnoiditis.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 11, 1948 *to* Feb. 3, 1949, *that I last saw the deceased alive on* Feb. 3, 1949, *and that death occurred at* 8.40P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	B. C. H. 4940 Eastern Ave.	Feb. 9, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	FEB 11 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
FEB 11 1949	Huntington Williams, M.D.	Commissioner of Health

VS 150

81a

✓ 420.1

G71448
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71443
Registered No.

1. NAME OF DECEASED (Type or Print) Pendleton P. Parrott

2. DATE OF DEATH Feb 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland [redacted]

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City 14
D. STREET ADDRESS (If rural, give location) 2131 Druid Hill Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2557 Francis St.

c. Length of stay in Baltimore Life Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored	Married	July 19, 1901	47	6 20	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School teacher	Public Schools	Baltimore, Md.	

13. FATHER'S NAME Pendleton P. Parrott

14. MOTHER'S MAIDEN NAME Veronica Saunders

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Dillard M. Parrott	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Heart disease — DUE TO — Sudden

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic hypertension — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-20-, 1948, *to* 2-9-, 1949, *that I last saw the deceased alive on* 2-2-, 1949, *and that death occurred at* 10:30 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. R. Campbell M. D.	718 Dolphin St.	2-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 12, 1949	Arbutus Mem. Park	Arbutus, Balto. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Countersigned for Registrar, M.D.	John M. Johnson	1700 Druid Hill Ave

VS 150

94a

G71444 ✓ 443 G71444

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Albert F. Warnecka
2. DATE OF DEATH: Feb. 8th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1104 Rutland Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1104 Rutland Ave. 8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Dec. 15th 1866	82	1 / 24	

10A. USUAL OCCUPATION (Give kind of work, even if retired): Butcher (Retired)
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Albert Warnecka
14. MOTHER'S MAIDEN NAME: Heinz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Isabella Warnecka ADDRESS: 1104 Rutland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Hemorrhage	6 Days
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO Hypertension Cardio Vascular disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) Bronchopneumonia	5 Days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 31, 1949 *to* Feb 8, 1949 *that I last saw the deceased alive on* Feb 7, 1949, *and that death occurred at* 5A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Fritz J. Heinz M.D.
23B. ADDRESS: 2700 Harford Road
23C. DATE SIGNED: Feb 9 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 11th 1949
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 11 1949
REGISTRAR'S SIGNATURE: Tunstall Williams M.D.
25. FUNERAL DIRECTOR: C. J. Fanning & Son
ADDRESS: 1936 E. Lafayette Ave

VS 150

937

G71445 ✓ 450.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71445

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie Stevenson

2. DATE OF DEATH: Feb. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 930 Wilmer Court

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 930 Wilmer Court

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	Colored	Widow	Jan. 10, 1863	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Maryland	U. S. A.

13. FATHER'S NAME: George Diggs

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Mr. Alexander Stevenson	611 Greenwillow

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — Interval between onset and death: 10 days

DUE TO

(B) Arterio Sclerosis — ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-29, 1949 *to* 2-9, 1949 *that I last saw the deceased alive on* 2-8, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Atwell Jones, M. D.	3 S. Dolphin St	2-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-12-49	Mt. Calvery Cem	Anne Arundel Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Huntington Williams, M.D.	Mrs. Frances A. Hersley	578 W. Biddle St.

VS 150

97

G71446

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 422.1 G71446

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Josephine Bokel

2. DATE OF DEATH: 2/9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3210 Elgin Avenue

c. Length of stay in Baltimore: 89 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3210 Elgin Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	9/5/58	90 89	5	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: --------

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Theodore A. Bokel

14. MOTHER'S MAIDEN NAME: Johanna Schroeder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Anna M. Urban ADDRESS: 417 York Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Myocarditis	about 1 yr.
DUE TO (B)	Arteriosclerosis	unknown
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/12, 1948, *to* Feb. 9, 1949, *that I last saw the deceased alive on* Feb. 8, 1949; *and that death occurred at* 10:45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. W. Morgetroth M.D.

23B. ADDRESS: 401 E. 25th. St. Balto. 18, Md.

23C. DATE SIGNED: 2/10/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/12/49	Holy Redeemer	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: FEB 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: W. W. Mears and Son ADDRESS: 503 N. Calvert St.

VS 150

9-7

BARNEY ✓443

G71447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71447

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ella Barney

2. DATE OF DEATH: Feb. 7, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days: Life.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1019 North Carrollton Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Married	June 26th 1886	62	—			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Baltimore, Maryland	America.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Albert Williams	Mary Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Husband	1019 N. Carrollton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic Ht. Disease	Unknown
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Essential Hypertension	"
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
—		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 7, 1949 *to* Feb 7, 1949 *that I last saw the deceased alive on* Feb 7 1949 *and that death occurred at* 5:15 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. K. Williams M. D.	1222 N. Caroline	Feb 10, 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 12, 1949	Randalltown	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Inserting for Williams M.D.	Mrs Katie K. Williams	322 N. Schroeder St.

VS 150

937

G71448 ✓ 442 G71448

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mary M. Smith.

2. DATE OF DEATH: 2-7-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1019 N. Carrollton Ave.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1019 N. Carrollton Ave 16 01

5. SEX: Female
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 10-4-1868
9. AGE (In years last birthday): 80 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland. Balto. Co.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Johnson
14. MOTHER'S MAIDEN NAME: Minerva ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: James Barney ADDRESS: 1019 N. Carrollton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage,	hrs.
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Hypertensive Cardio	1-3-49
DUE TO	Vascular Renal Disease	
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-3, 1949 *to* 2-7, 1949 *that I last saw the deceased alive on* 2-7, 1949, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. Cleckley M. D.
23B. ADDRESS: 803 W. Franklin St.
23C. DATE SIGNED: 2-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 12, 1949
24C. NAME OF CEMETERY OR CREMATORY: Randallstown
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 11 1949
REGISTRAR'S SIGNATURE: Huntington Mitchell, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R Williams Schroeder Sr
ADDRESS: 321 N

VS 150

1310

G71449 ✓ 334 G71449

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): LOUIS GUSTAV PEPPLER
2. DATE OF DEATH: Feb. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1814 N. Chester Street
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1312 Poplar Grove Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widower	Dec. 31, 1876	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alexander Peppler
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Louis A. Peppler- 1814 N. Chester St (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Apoplectic stroke — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Essential hypertension — 7 yrs.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 3, 1949 *to* Feb 9, 1949 *that I last saw the deceased alive on* Feb 7, 1949, *and that death occurred at* 9:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Conrad D. Pretter M. D.
23B. ADDRESS: 1706 N Washington St
23C. DATE SIGNED: 2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/12/49	Greenmount	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 3rd 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR (ADDRESS): HENRY SANDER & SONS, INC.

BALTIMORE - 13, MARYLAND 83a

G71430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 G71430

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): CORA WOLF

2. DATE OF DEATH: February 10, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2306 Belair Road
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2306 Belair Road

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 6, 1880
9. AGE (In years last birthday): 69 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Hess
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. george wolf - ADDRESS: 2306 Belair Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Chronic Nephritis	about 18 months
DUE TO (B)	Chronic Myocarditis	" 4 yrs
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Hypertension, Arterio Sclerosis	7 months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Ascites, Gen'l Dropsy	4 yrs

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1944, *to* Feb 10, 1949, *that I last saw the deceased alive on* Feb 10, 1949, *and that death occurred at* 5.55 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter E. Krickman M. D.
23B. ADDRESS: 225 Dundalk Rd
23C. DATE SIGNED: Feb 10 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/14/49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC. ADDRESS: BALTIMORE - 13, MARYLAND

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G71451 ✓ 002 G71451

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): HERMAN WILLIAM HAGANS

2. DATE OF DEATH: Feb. 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 514 Pearl Street

C. Length of stay in Baltimore: 20 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 514 Pearl Street 12-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	Negro	Married	July 4, 1909	39 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Burner	Beth. Steel Co.	Wilson, North Carolina	

13. FATHER'S NAME: William Hagans

14. MOTHER'S MAIDEN NAME: Emma ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	218-09-4897	Fayet Hagans	514 Pearl Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ..... DUE TO

(C) .....

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 9 Mos.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	[illegible]	2-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/13/49	Mt Calvary Cemetery	Brooklyn, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	[signature]	CHARLES R. LAW	802 Madison Avenue

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G71452 ✓ 173 G71452

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Emma J. Smith
2. DATE OF DEATH: 2/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1027 Union Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
c. Length of stay in Baltimore: Life. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D STREET ADDRESS (If rural, give location): 1027 Union Ave. 13

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married.	June 28 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife.	—	Md.	

13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—	—	Lawrence E. Smith	1027 Union Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Uterus
DUE TO
(B) Generalized Carcinomatosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 47, *to* Feb 10, 49 *that I last saw the deceased alive on* Feb 4, 49, *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lawrence J. Ehrmann M. D.	3711 Falls Rd	2-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/12/49	St Marys	Hampden.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	[illegible] for Wilmington, N.C.	Paul E. Ehrmann & Son	3457 Eastern Ave

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G71453

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

332 G71453 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES HENDERSON MOOREFIELD

2. DATE OF DEATH: 2/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp

C. Length of stay in Baltimore: Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Long ville
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	M	May 26 83	65 66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Iron molder		North Carolina	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
P. H. Moorefield	Nancy Wood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

(B) Generalized Arteriosclerosis ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/5 *1949, to* 2/10 *, 1949 that I last saw the deceased alive on* 2/10 *19*49*, and that death occurred at* 3 40 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles J. Black M.D.	Maryland General	2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 12, 49	Fork Cemetery	Fork Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949		J. E. Arthur	Fork Md.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G71454 — 521 G71454 — Registered No.

1. NAME OF DECEASED (Type or Print): Sagatel Esahakian

2 DATE OF DEATH: February 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U. S. Marine Hospital

c. Length of stay in Baltimore: unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: -
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 800 S. Broadway

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	single	July 15, 1888?	60	6	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
cook	seafaring	Armenia	U.S.A.

13. FATHER'S NAME: Alex Esahakian

14 MOTHER'S MAIDEN NAME: Shugten ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
	168-09-2333	Records, U.S.Marine Hospital, Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hemorrhage during right pneumonectomy	
DUE TO (B)	Abscess pulmonary, right	Unknown
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
2/9/49	Lung abscess	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* January 3, 1949 *to* February 9, 1949 *that I last saw the deceased alive on* February 9, 1949, *and that death occurred at* 12:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE AND TITLE OF PHYSICIAN	23B ADDRESS	23C DATE SIGNED
John L. Rinehart, Sr. Surgeon Chief Medical Director M. D.	US Marine Hospital, Balto, Md.	2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/12/49	Sacred Heart	Boots. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 11 1949	Functioning for Williams, M.D.	Lilly Zeller INC. 403 S. Wolfe St

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BIRTH NO. 671435

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 671435 Registered No.

1. NAME OF DECEASED (Type or Print): FRANKLIN REDMOND

2. DATE OF DEATH: February 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 225 S. Broadway

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 10/28/1892
9. AGE (In years last birthday): 66 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seaman
10B. KIND OF BUSINESS OR INDUSTRY: Seafaring
11. BIRTHPLACE (State or foreign country): Ohio.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Walter Redmond
14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: U.S. Maritime Union — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute congestive heart failure
DUE TO Hypertensive cardiovascular disease
(B) Generalized arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 2-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/14/49
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Lilly & Zile Inc ADDRESS: 403 S. Wolfe St.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Warren

2. DATE OF DEATH: 2/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2259 Sidney Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	1/1	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mattress Maker			

13. FATHER'S NAME: Aaron Warren

14. MOTHER'S MAIDEN NAME: Melinda Stone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure (acute)
DUE TO
(B) Acute Coronary Occlusion
DUE TO
(C) Rheumatic C-V Dis. (Aortic)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/26 1949 *to* 2/10 1949 *that I last saw the deceased alive on* 2/9 1949 *and that death occurred at* 7:50A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas. E. Carr M. D.	St Agnes Hosp.	2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Feb 12 1949	Cathedral Cemetery	4500 Frederick Ave Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Huntington Williams M.D.	Thomas E. Kenney Jr.	1600 Holland St 92c

VS 150

G71457

CERTIFICATE CORRECTED 9-28-53

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71457

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Also known as Pasqualina Nardone
Mrs. Esther Dolores Nardone

2. DATE OF DEATH Feb. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St. Joseph

c. Length of stay in Baltimore 36yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 828 East Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Fe.	White	Married	June 7, 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hwfe.		Italy	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nicolo Astuni.	Angelini Metrotti

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		John L. Nardone 828 S. East Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema
DUE TO
(B) Carcinoma of Lung Bilaterally
DUE TO
(C) Metastasis from Urinary Bladder

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/9/ , 1949, *to* 2/10/ , 1949 *that I last saw the deceased alive on* 2/10/ , 1949, *and that death occurred at* 2:20 AM., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip A. Peta M.D.	1400 N. Caroline Street	2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/14/49	Sacred Heart	German Hill Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 11 1949	Lennington Williams, Jr.	Clarence F. Hoffmann 1639 Broadway.

VS 150

526

G71458 ✓ 442

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71458

1. NAME OF DECEASED (Type or Print): Edith M.Boehm

2. DATE OF DEATH: Feb 10 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3017 Beverly Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 66 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3017 Beverly Road 27-02

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Jan 28 1880
9. AGE (In years last birthday): 69 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Ludwig Gohr
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: Edith B.Decker 3017 Beverly Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypostatic Pneumonia	3 days.
DUE TO (B)	Hypertensive cardiovascular renal disease	Yrs?
DUE TO (C)	Gangrene of foot	10 days.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1949 *to* Feb 10, 1949, *that I last saw the deceased alive on* Feb 9, 1949, *and that death occurred at* 8.25 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Geo. D. Slater M. D.
23B. ADDRESS: 432 N Patterson Park Ave
23C. DATE SIGNED: 2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 14 1949
24C. NAME OF CEMETERY OR CREMATORY: Oaklawn
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams Jr
25. FUNERAL DIRECTOR: Harry J. Timanus
ADDRESS: 4204 Ridgewood Ave

VS 150

131a

AB-126634

G71459

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

330

Registered No. G71459

1. NAME OF DECEASED (Type or Print): Gladys M. Scott

2. DATE OF DEATH: Feb. 10-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 22 yrs. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chase (Rural)
D. STREET ADDRESS (If rural, give location): Eastern Avenue, Chase, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Married	May 8- ?	39?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Eddie Keyes
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT ADDRESS: Baltimore City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Sub-Arachnoid hemorrhage	6 days
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-5- , 1949, *to* 2-10- , 1949 *that I last saw the deceased alive on* 2-10- , 1949 *and that death occurred at* 6.25 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: Feb. 10-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 14 49
24C. NAME OF CEMETERY OR CREMATORY: Sharp St Cem.
24D. LOCATION (City, town, or county) (State): Chase Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR ADDRESS: Mrs Robt. J. Elliott Dft 1129 N Caroline St 82a

VS 150 - 6

G71460 Reuwer ✓ X

BALTIMORE CITY HEALTH DEPARTMENT 200-1 G71460

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Charles H. Reuwer

2. DATE OF DEATH 2-10-49 3:30 PM

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto General

c. Length of stay in Baltimore 59 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, or institution's residence before admission) A. STATE B. COUNTY 3624 Sussex Rd - Milford

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Milford - Md

D. STREET ADDRESS (If rural, give location) 3624 Sussex Rd - Milford

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Oct. 6, 1889	59	4	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer - Bureau of Chukes

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore - Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Ferdinand Reuwer

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Charles H. Reuwer ADDRESS 5803 Woodcrest

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 2-9, 1949 *to* 2-10, 1949 *that I last saw the deceased alive on* 2-10, 1949 *and that death occurred at* 3:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Albert Abramson M. D. 23B. ADDRESS W.S.S. 10. 23C. DATE SIGNED 2-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 2-14-49 24C. NAME OF CEMETERY OR CREMATORY New Cathedral 24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 11 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR Ellsworth Armacost ADDRESS 3911 Liberty Hgts

VS 150

55E

G71461
BIRTH NO.

E 903.0
N 820.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71461
Registered No.

1. NAME OF DECEASED (Type or Print): Dr. William D. Thomas
2. DATE OF DEATH: 2/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institutional residence, give last usual residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
250 Glenmore Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 250 Glenmore Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 7/4/1864
9. AGE (In years last birthday): 84
If Under 1 Year: Months 7, Days 5
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): M.D.
10B. KIND OF BUSINESS OR INDUSTRY: Doctor
11. BIRTHPLACE (State or foreign country): Mo.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph A. Thomas
14. MOTHER'S MAIDEN NAME: Martha M. Redgrave
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mildred D. Thomas
ADDRESS: 250 Glenmore Ave Catonsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar pneumonia - Rt. — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO
(B) Arterio-sclerotic Cardio-Vascular disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

CERTIFICATION APPROVED BY
for: C.J. Rubinski, M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fract neck of Rt. hip. — 10 days.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home.
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 250 Glenmore Ave., Catonsville, Md.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 12-26-48 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Pt. slipped at home.

22. *I hereby certify that I attended the deceased from* 12-27 19[illegible] *and* 2/9 19[illegible], *that I last saw the deceased alive on* 2/9 19[illegible], *and that death occurred at* 11:30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Arthur J. Hall Jr. M.D.
23B. ADDRESS: St. Agnes Hosp.
23C. DATE SIGNED: 2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: 2/12/49
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc.
ADDRESS: 1217 St. Paul St

VS 150

186a

671462 BALTIMORE CITY HEALTH DEPARTMENT 193 671462

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Cuthbert Harry Rogerson, M.D.

2. DATE OF DEATH: 2-10-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore; D. STREET ADDRESS (If rural, give location) 3803 Beech Ave., Balto. 11, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Institute

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	White	Married	5-25-1909	39	8	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? British Subject

13. FATHER'S NAME: Harry Finch Rogerson

14. MOTHER'S MAIDEN NAME: Margaret Collingwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

16. SOCIAL SECURITY NO:

17. INFORMANT: The Seton Institute — ADDRESS: Balto. 10, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brain tumor (Glioblastoma) — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Apr. 14, 1948

19B. MAJOR FINDINGS OF OPERATION: Cerebral tumor - glioblastoma

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): None

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-14, 1948, *to* 2-10, 1949, *that I last saw the deceased alive on* 2-10, 1949, *and that death occurred at* 6:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert Lee Meiss, M.D. — 23B. ADDRESS: The Seton Institute — 23C. DATE SIGNED: 2-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation — 24B. DATE: 2/12/49 — 24C. NAME OF CEMETERY OR CREMATORY: Greenmount — 24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 11 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 St Paul St

VS 150

54a

G71463

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 260

G71463

BIRTH NO.

1. NAME OF DECEASED (Type or Print): PANSY M. STAINES

2. DATE OF DEATH: Feb. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3819 Pleasant Place

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3818 Pleasant Place

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Jan. 9, 1899	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Knight

14. MOTHER'S MAIDEN NAME: Josephine Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT — ADDRESS: Emory Staines, 3819 Pleasant Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	1 hr.
DUE TO (B)	Art. Sclerosis	2 yrs.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Diabetes Mellitus	2 yrs.
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

21E. INJURY OCCURRED: WHILE AT WORK ☐ — NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Jan. 1st, 1946 *to* Feb. 10th, 1949, *that I last saw the deceased alive on* Feb. 10th, 1949, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: James A. Miller M.D.

23B. ADDRESS: Pikesville, Md

23C. DATE SIGNED: 2/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/14/49

24C. NAME OF CEMETERY OR CREMATORY: National

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 11 1949

REGISTRAR'S SIGNATURE: Instructor for Williams, MD

25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 150

61

G71464

337 G71464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MATILDA CHASE WICKERT

2. DATE OF DEATH: Feb.10,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3023 St. Paul St
c. Length of stay in Baltimore (Yrs. Mos. Days):

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3023 St. Paul St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	July 10,1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William H. Baer	Elizabeth Cherry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No	None	Mrs L.W.Kelly, 3023 St. Paul St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio Sclerosis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* February 8, 1949 *to* 2-10-, 1949 *that I last saw the deceased alive on* 2-10, 1949, *and that death occurred at* 9:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Kelly Wicks M.D.	3023 St Paul St.	2-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/12/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 11 1949	Huntington Williams M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

83a

G71465 ✓ 610 G71465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) GAY, ALBERT THOMAS

2 DATE OF DEATH FEB. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Sinai Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore 6 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE
B COUNTY 1720 Eutaw Place
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md —
D. STREET ADDRESS (If rural, give location) 1720 Eutaw Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	white	married	Mch 10. 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Clerk. May Co.	South Wales	U. S.

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no		Thomas M. Gay	3017 Lauderdale Ct. Balto. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY EMBOLUS — INTERVAL BETWEEN ONSET AND DEATH: 30 MINS.

DUE TO

(B) FOLLOWING PROSTATECTOMY — 9 DAYS

DUE TO

(C) CORONARY INSUFFICIENCY

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
FEB. 1, 1949	BENIGN HYPERTROPHY OF PROSTATE	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JAN. 23, 1949 *to* FEB. 10, 1949, *that I last saw the deceased alive on* FEB. 10, 1949, *and that death occurred at* 1:50 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C. DATE SIGNED
Samuel Lerman M. D.	Sinai Hospital	FEB. 10, 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feby. 12/49	Fort Lincoln Cemetery	Washington D C

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Huntington Williams M.D.	John O. Mitchell Sons	1900 Eutaw Place

VS 150

137a

671466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

151

671466

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) EMMA BROWN

2. DATE OF DEATH Feb. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE #15
D. STREET ADDRESS (If rural, give location) 3021 Ridgewood Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	W	Widowed	11/1/88	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Penna.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Leo Schreiber	Josephine Haas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Helen Raffensberger	3021 Ridgewood Baltimore Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pulmonary embolus

DUE TO

(C) Carcinomatosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

liver

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2/7/49	Generalized carcinomatosis	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/2/ , 1949 *to* 2/10 , 1949, *that I last saw the deceased alive on* 2/10/ , 1949, *and that death occurred at* 1:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert Lantz M. D.	Sinai Hospital	2/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2/11/49		Altoona, Penna.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Deputy for Registrar, Md.	John A. Moran	3000 E Balto St

VS 150

46B

G71467

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 756.2

Registered No. G71467

BIRTH NO. B.C. 49-01769

1. NAME OF DECEASED (Type or Print): Baby Goldschmidt

2. DATE OF DEATH: 2/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3120 E. Baltimore St.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	1/28/49			13

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Harry Goldschmidt

14. MOTHER'S MAIDEN NAME: Bertha Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure

DUE TO

(B) Gastrostomy

DUE TO

(C) Congenital Atresia of Pylorus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑
2/2/49	Congenital Atresia of Pylorus	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2/2/49 *to* 2/10/49, *that I last saw the deceased alive on* 2/10/49, *and that death occurred at* 5:25 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter J. Bergamot M. D.	St. Agnes' Hospital	2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 12 1949	Parkwood Mem Gardens	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Dorothy Fox Williams, Asst.	John C. Moran	3000 E Baltimore St

VS 150

1579

G71468 CERTIFICATE CORRECTED 2-28-49 ✓ 420.1 G71468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Costantino R Raimondi

2. DATE OF DEATH Feb. 9 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3708 Gwynn Oak Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 30 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 2
3708 Gwynn Oak Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore Md.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Jan. 27 1893	56	21	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Grocery Store		Italy	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Domenico R Raimondi	Giuseppina Mancini

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mary Di Simone	2701 Sothern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	Sudden
DUE TO (B)	Angina Pectoris	8 yrs.
DUE TO (C)	Arteriosclerosis	8 yrs.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	None.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr. 27, 1940 *to* Feb. 9th, 1949, *that I last saw the deceased alive on* Dec. 10, 1948, *and that death occurred at* 10:50 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred L. De Barbieri M. D.	4723 Park Heights Ave.	Feb. 11 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 12 1949	Holy Redeemer Cemetry	Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Huntington	Frank Della Rocca	322 S. High St.

VS 150

94a

G71469 ✓442 G71469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Dora Kaline
2. DATE OF DEATH: Febr. 10 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2203 Sidney Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 78 Yrs. five Mos. 22 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 2203 Sidney Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months Days	If under 24 hours: Hours Min.
female	white	widowed	Dec-19-1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore	U.S.A.

13. FATHER'S NAME: Robert Creighton
14 MOTHER'S MAIDEN NAME: Sara Jane Gable

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	none	Bryan Kaline	2203 Sidney Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) cardio-vascular-renal disease DUE TO
ANTECEDENT CAUSES
(B) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: about 4 years.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1948 *to* Febr. 10-, 1949 *that I last saw the deceased alive on* 2-9-, 1949, *and that death occurred at* 3 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C DATE SIGNED
Walter H. Sonnenfeldt M. D.	2708 Hollins Ferry Road	2-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	2/14/49	Western Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Huntington Holdsworth, M.D.	C. Vernon Lemmon	4611 Park Heights.

VS 150

131a

G71470

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 776 G71470

BIRTH NO. B.C. 49-0143

1. NAME OF DECEASED (Type or Print): Babe Shipley "A"

2. DATE OF DEATH: 1-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ~~1317 Monroe St.~~ U., Balto. City Hosp

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1317 N. Monroe St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	C	Single	1-8-49			4hr35mi

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	c	Baltimore, Md.	

13. FATHER'S NAME: William Edward Shipley

14. MOTHER'S MAIDEN NAME: Jeanette Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Hospital Records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
M.D.		1-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School JAN 13 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 151

6

159

G7147.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

776 G7147.1

Registered No.

BIRTH NO. B.C. 49-01438

1. NAME OF DECEASED (Type or Print): Babe Shipley "B"

2. DATE OF DEATH: 1-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1317 N. Monroe St.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Single	1-8-49			50

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	

13. FATHER'S NAME: William Edward Shipley

14. MOTHER'S MAIDEN NAME: Jeanette Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Hospital Records	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Prematurity	
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23. SIGNATURE	M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
[signature]			1-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	JAN 13 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1 1949	Huntington Wil...	Commissioner of Health	

Cancel age if especially important. Physician: please write the cause of death clearly and legibly.

VS 151

6

159

6714.72

581.0 ✓

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6714.72

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Josephine (C.E.S.) Sophia A. Kvech

2. DATE OF DEATH Feb 10,1949

3. PLACE OF DEATH: A. Baltimore City, Maryland South Baltimore General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland. B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 4111 Highland Ave, Brooklyn, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	March 15,1905	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Curtis Bay, Md.	U.S.A.

13. FATHER'S NAME Frank J. Kvech Sr., (C.E.S.)

14. MOTHER'S MAIDEN NAME Baburek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Parents,	4111 Highland Ave. Brooklyn

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hepatic cirrhosis	2 yr
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(1) Aplastic anemia (2) Rheumatoid arthritis (3) Bronchio pneumonia	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 8, , 1948, *to* Feb 10, , 1949, *that I last saw the deceased alive on* Feb 10, , 1949, *and that death occurred at* 8P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William T. Haun, M. D.	Bayll Baltimore Gen Hospital	2-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/14/49	Holy Cross	Annapolis Blvd. (C.E.S.)

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Huntington / Indiana, Md.	Schimunek Funeral Home Inc	2601-03-05 E. Madison

VS 150

124B

G71473 ✓ 422.2 G71473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Louise C Gough
2. DATE OF DEATH: Feb 9 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 213 Paddington Rd
c. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 213 Paddington Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year last Birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F.	W.	Married	Aug 24 1877	71	5	16		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
✓	–	Balto Md	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frederik P Faust	Mary S. Waidner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
✓	✓	✓	J Lee Gough	213 Paddington Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Insufficiency
DUE TO
(B) Pulmonary Edema
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 8, 1949 *to* Feb 9, 1949 *that I last saw the deceased alive on* Feb 9, 1949 *and that death occurred at* 8 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. John G. Dunn M.D.	26 E. Preston St	Feb 10 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 12 1949	London Park	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949	Thurlington Williams, M.D.	Henry W Jenkins & Sons Co	4905 York Rd

VS 150

93E

G71474 ✓ G71474

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 443

CERTIFICATE OF DEATH 422.1

Reg. Dist. No. .....

1. PLACE OF DEATH
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: [illegible]
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Gardenville Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): [illegible] Belair Rd.

3. NAME OF DECEASED (Type or Print): (First) Emily (Middle) G. (Last) Collins

4. DATE OF DEATH: (Month) Feb. (Day) 10 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Aug. 17 1872

9. AGE last birthday: 76 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington D. C.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Joseph Fought

14. MOTHER'S MAIDEN NAME: Adelia A. Faulkner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT: Mrs. Wanda Gates

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute myocardial insufficiency	2 weeks
Antecedent cause(s)	(b) Arteriosclerosis (generalized)	?
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Hypertensive Cardio-vascular disease	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Jaundice Chronic passive hepatitis 5 days

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 9, 1948 to Feb. 10 1949 that I last saw the deceased alive on Feb. 9, 1949, and that death occurred at 10:10 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. W. Harbold M.D. ADDRESS: 4706 Harford Road Baltimore Md DATE SIGNED: 2/11/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 2/12/49
NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
LOCATION (City, town, or county) (State): Baltimore, Co. Md.

DATE REC'D BY LOCAL REG.: FEB 11 1949
REGISTRAR'S SIGNATURE:
24. FUNERAL DIRECTOR: William J. Fickner & Sons ADDRESS: North & Pa. Aves

93

G71475 ✓ 260 G71475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MAE ALLEN

2. DATE OF DEATH: 2/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEST BALTO. GEN. HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1730 Bloomingdale Rd.

5. SEX	6. COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
F	W		April 9, 1885	63 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
		Pittston, Pa.	

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
John Baker	Henrietta Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Mr. Frank J. Allen 1730 Bloomingdale Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CORONARY ARTERY OCCLUSION

DUE TO

(C) DIABETES MELLITUS

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/5/, 49 *to* 2/10/ 19 49 *that I last saw the deceased alive on* 2/10/ 19 49 *and that death occurred at* 11:15 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. A. Golombek M. D.	West Balto Gen Hosp	2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/14/49	Lorraine Cem.	Woollawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 14 1949		WM. J. TICKNER & SONS	Balto., Md.

FEB 1-1949 Vs 150

8 61

G71476 ✓ X G71476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

151 Registered No. 786017

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Gonzalo Salazar
2. DATE OF DEATH: Feb. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: Yrs. 6 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: District of Columbia
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington
D. STREET ADDRESS (If rural, give location): 2705 Woodley Pl. N.W.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white		1-10-85	64 63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Journalist		Peru So. America	

13. FATHER'S NAME: Federico Salazar
14. MOTHER'S MAIDEN NAME: Petrita Gonzalez

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		Johns Hopkins Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of stomach	1 year
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Jan 11, 1949	Carcinoma of stomach	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/4 1949 *to* 2/11 1949 *that I last saw the deceased alive on* 2/11 1949 *and that death occurred at* 11:50 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Hall M. D.	Johns Hopkins Hospital	Feb 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Wash. Nat'l.	Suitland Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
FEB 14 1949	[illegible]	W. W. Chambers Co 1400 E Chapin St Md 10. C. 463

G714.47 BALTIMORE CITY HEALTH DEPARTMENT 583 G714.47

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGIA SUTTON

2. DATE OF DEATH: 2 · 11 · 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALDWIN
D STREET ADDRESS (If rural, give location)

5. SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
FEMALE	WHITE		Oct 20 1876	72 73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY
HOUSE WIFE		MARYLAND	

13. FATHER'S NAME: CHARLES BREWER

14 MOTHER'S MAIDEN NAME: MARY WILLIAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
		J. THOMAS SUTTON	BALDWIN Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	OBSTRUCTIVE JAUNDICE	2 WKS
DUE TO	CAUSE UNDETERMINED	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	TERMINAL PNEUMONIA	2 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
NONE		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2 · 5 1949 *to* 2 · 11 1949, *that I last saw the deceased alive on* 2 · 11 1949, *and that death occurred at* 1135 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Richard L. Martin M. D.	Maryland General Hospital	2 · 11 · 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Feb. 14-1949	Wesley Chapel	Monkton, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 11 1949		Howard S. Mankins	Monkton Md

VS 150

1278

G71478 ✓002 G71478

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Howard Bishop Harter

2. DATE OF DEATH: 2-9-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2525 W. Fairmount Ave

C. Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2525 W. Fairmount Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	Feb. 18-1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cabinet Maker-Furniture	Henry L. Stallings	Balto. Maryland.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John V. Harter.	Sarah E. Dugheday

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW I	214-03-7478	William M. Harter	2525 W. Fairmount

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pulmonary Hemorrhage	One hour.
DUE TO	Pulmonary Tuberculosis.	24 years
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1st, 1948, to ~~Feb~~ 9, 1949, *that I last saw the deceased alive on* ~~Feb~~ 9, 1949 *and that death occurred at* 10:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm Mitchell M.D. M. D.

23B. ADDRESS: 1921 Edgewood Road

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-12-1949

24C. NAME OF CEMETERY OR CREMATORY: Balto. National Cem.

24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 12 1949

REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR: F. B. Wippert & Son

ADDRESS: 600 Fulton Ave

VS 150

13B 17

G71479

BALTIMORE CITY HEALTH DEPARTMENT 331 . G71479

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) RICHARD A. SAALBACH

2. DATE OF DEATH 2/9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4703 Hampnett Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City 27-7

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pine Ridge Nursing Home

c. Length of stay in Baltimore 35 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 3405 Keene Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
male	white	married	3/7/68	80	11	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. Army

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Germany

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME August Saalbach

14. MOTHER'S MAIDEN NAME Maria Sorge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or dates of service) U.S. Army

16. SOCIAL SECURITY NO.

17 INFORMANT ADDRESS Mrs. Richard A. Saalbach 3405 Keene Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 days

DUE TO

(B) Hypertension — 3 years

DUE TO

(C) Arteriosclerosis — 8 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Jan 29th 1949 *to* Feb 9th 1949, *that I last saw the deceased alive on* Feb 9th 1949, *and that death occurred at* 5-20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE L. L. Grady M. D.

23B. ADDRESS 5106 Harford Road

23C. DATE SIGNED Feb 10 '49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial

24B. DATE 2/12/49

24C. NAME OF CEMETERY OR CREMATORY Parkwood

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 12 1949

REGISTRAR'S SIGNATURE Curtis Worthington Williams, M.D.

25 FUNERAL DIRECTOR Lasacka Funeral Home ADDRESS 7401 Belair Rd.

VS 150

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671480 ✓ 331 671480

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM CARTER LEWIS

2. DATE OF DEATH: Feb. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Marine Hospital, Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: 25 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1813 Presstman St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	Months	Days	Hours	Min.
M	col	Widower	Jan. 15, 1895	54	0	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Va.	USA

13. FATHER'S NAME: John Lewis

14. MOTHER'S MAIDEN NAME: Susie Banks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
Yes	WW I		Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage cerebral — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

Contributory:

(B) Hypertensive cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Feb. 7, 1949 *to* Feb. 11, 1949, *that I last saw the deceased alive on* Feb. 11, 1949, *and that death occurred at* 4:45A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Sr. Surgeon M. D.	US Marine Hospital, Balto, Md.	2/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 14, 1949	Balto. National	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 12 1949	Huntington Williams M.D.	Charles R. Law, 802 Mad. Ave.

VS 150

937

✓ 593 G71481

G71481
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) MARY OXBERGER

2. DATE OF DEATH 2/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 133 W. LEE. ST.

c. Length of stay in Baltimore 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 133 W. LEE. ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	May 7 1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
nurse -		N. Carolina	

13. FATHER'S NAME John Dixon

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Nettie Gries	2004 Ramsay

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 4 attacks in last 3 years.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension nephritis.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 10 1944 *to* Feb 9, 1949 *that I last saw the deceased alive on* Feb. 9, 1949 *and that death occurred at* 1:50 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Franklin M.D.	1122 W. Lee St	2/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Feb. 12 '49	New Cathedral	4300 Old Frederick Rd - Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 12 1949	[illegible]	Henry A Witzke	4101 Edmondson Ave

VS 150

131a

BROMMUND

G71482 ✓ 604 G71482

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Brommund, Sina (Habardine)

2. DATE OF DEATH: Feb. 10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: 53 yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1836 Ramsay St. 19-04

5. SEX: Female
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 2, 1869.
9. AGE (In years last birthday): 79 — If Under 1 Year: Months 8, Days 8 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Conrad Hille
14. MOTHER'S MAIDEN NAME: Marguerite Portner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: husband — ADDRESS: Albert C. Brommund, 1836 Ramsay St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease & Failure

DUE TO

(B) Pulmonary Edema & Congestion

DUE TO

(C) Acute and chronic Cystitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: Feb 4
19B. MAJOR FINDINGS OF OPERATION: bladder calculus
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 29, 1949 *to* Feb 10, 1949 *that I last saw the deceased alive on* Feb 10, 1949, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Judith B. Landau M.D.
23B. ADDRESS: Sinai Hospital, Balto Md
23C. DATE SIGNED: 2-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 14/49
24C. NAME OF CEMETERY OR CREMATORY: St. Paul's, 5600 Cardiff Ave. Balto. Md.
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: FEB 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Harry N. Nitzke
ADDRESS: 4101 Edmondson Ave.

VS 150

134B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

071483

BALTIMORE CITY HEALTH DEPARTMENT ✓ 331 Registered No. 071483

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2418 CALVERTON HEIGHTS AV.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE 16-05 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2418 CALVERTON HEIGHTS AV (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMA C. BUSSARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife late WILLIAM E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 17, 1878

8. AGE: Years	Months	Days	If less than one day
71	0	23	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name JOHN A. SCHAFER
13. Birthplace MD.

MOTHER 14. Maiden Name PRISCILLA CLARK
15. Birthplace MD.

16 (a) Informant MRS FLORENCE E ZACKS
(b) Address 2418 CALVERTON HGHTS. AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 12 1949 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Harry A Wiltshe
(b) Address 4101 Edmondson Ave

19 (a) FEB 12 1949 (Date rec'd by registrar) (b) Burlington Wilt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 10 1949 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8-49 19 , to 2-10 1949. and that I last saw h[illegible] alive on 2-9-49 19 .

Immediate cause of death: Cerebral hemorrhage — Duration: 1 day
Due to Generalized arteriosclerosis — yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry L. Gumbel M.D.
Address 703 Edmondson Date signed 2-10-49

VS 150

83a

G71484 — 60 — G71484

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mary Ellen Hall

2. DATE OF DEATH: Feb. 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1423 N. Lanvale St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 5a Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16 or
D. STREET ADDRESS (If rural, give location): 1423 N. Lanvale St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Married	Sept. 30 1875	73	—	—		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	Domestic	Lancaster Co. Va	U. S. A.

13. FATHER'S NAME: Henry Johnson

14. MOTHER'S MAIDEN NAME: Belle ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Mrs. Justine Smith	1423 N. Lanvale St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Diabetes Mellitus	3 months
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Arteriosclerosis, Hypertensive Heart Disease	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/1/49, 19—, *to* 2/8/49, 19—, *that I last saw the deceased alive on* 2/8/49, 19—, *and that death occurred at* 11:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. Bordley Higgins M. D.	7743 Madison Ave	2/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/12/1949	Arbutus Mem. Pk.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 12 1949	Huntington Williams, M.D.	Mrs. George H. Holland	1703 Eutaw Pl

61

G71485

BALTIMORE CITY HEALTH DEPARTMENT 422.2

CERTIFICATE OF DEATH

Registered No. G71485

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 W Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Baltimore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
80	-	-	hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation Not Employed

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Estella Hooper (Niece)
(b) Address 1303 W Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12th 19 49 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cemetary
Location Brooklyn Md

18 (a) Funeral director Bloy O Wilson
(b) Address 1000 Pennsylvania Ave

19 (a) FEB 12 1949 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1949, at 8 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1949 to Feb 9 1949, and that I last saw h alive on Feb 9 1949.

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M H Patterson M. D.
Address 2324 Reisterstown Rd Date signed 2/11/49

VS 150

937

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G71486 ✓ 422.2 G71486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 199.1

BIRTH NO. | Registered No. 3698

1. NAME OF DECEASED (Type or Print): Rufus M. Gardner

2. DATE OF DEATH: Dec. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1043 N. Mount St.
c. Length of stay in Baltimore: 50. Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1043 N. Mount St. 16-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Col.	Married	Nov. 28. 1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): A.A.Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Gardner
14. MOTHER'S MAIDEN NAME: Catherine Gardner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Reginald Gardner ADDRESS: 500 Sanford Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of face — INTERVAL BETWEEN ONSET AND DEATH: over 1 year
DUE TO
(B) Myocarditis — unknown
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-5-, 1949, *to* 2-9-, 1949, *that I last saw the deceased alive on* 1-8-, 1949, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Frank A. Saunders M. D.
23B. ADDRESS: 1029 N. Strieker St.
23C. DATE SIGNED: 2-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/12/1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Arburn Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949
REGISTRAR'S SIGNATURE: Evelyn Williams, M.D.
25 FUNERAL DIRECTOR: Elroy O, Wilson ADDRESS: 1000 Brantly Ave

VS 150

55E

Correct age is especially important. Physician please write the cause of death clearly and legibly.

71487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

442 71487 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frank H. Berryman

2. DATE OF DEATH: 2-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1317 Madison Avenue

C. Length of stay in Baltimore: 50 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 914 Madison Avenue 11-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	C	Widowed	November 6, 1874	74 75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown		Lexington, Kentucky	America

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No	None	Mrs. E. Williams - 1317 Madison Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular-Renal Disease — Interval between onset and death: 6 mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Uremia — Interval between onset and death: 3 days

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* February 8th, 1949, to February 10, 1949, *that I last saw the deceased alive on* February 10, 1949, *and that death occurred at* 2:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. L. Neilson M. D.	600 N. Arlington Ave.	2-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	February 14, 1949	Mount Lion	Baltimore County Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
FEB 12 1949	Huntington Williams, M.D.	Joseph A. Sindy 66 West Pane St.

VS 150

131a

Physician please write the cause of death clearly and correct age is especially important.

G71488 Dr. Gordy

443 G71488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna E. Holland

2. DATE OF DEATH: Feb. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5130 Harford Road
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5130 Harford Road

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: July 22, 1897
9. AGE (In years last birthday): 51 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John C. Munder, Sr.
14. MOTHER'S MAIDEN NAME: Anna Kleinefelder
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Margaret West, ADDRESS: 8730 Harford Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension — DUE TO — 6 years

(C) Hemiplegia — 2 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITIDN CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 15th, 1944 *to* Feb 11th, 1949, *that I last saw the deceased alive on* Feb 10th, 1949, *and that death occurred at* 8:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. L. Gordy M.D. M. D.
23B. ADDRESS: 5106 Harford Road
23C. DATE SIGNED: Feb 11th 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-14-49
24C. NAME OF CEMETERY OR CREMATORY: Fork M.E.Ch. Cem.
24D. LOCATION (City, town, or county) (State): Fork Maryland

DATE RECEIVED BY LOCAL REGISTRAR: FEB 12 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR, ADDRESS: Leonard J. Ruck, 5305 Harford Road.

VS 150

937

Physician please write the cause of death clearly and if by accident age is especially important.

G71489 Colley

443 G71489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): IDA BELL ORCHARD

2. DATE OF DEATH: Feb. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1425 Kingsway Road

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1425 Kingsway Road 2-7-49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	widowed	June 5, 1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Maryland	

13. FATHER'S NAME: Jacob Hammel

14. MOTHER'S MAIDEN NAME: Margaret A. Meredith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Miss Ida Perry	1425 Kingsway Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Hemorrhage, cerebral	6 weeks
	DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	Hypertensive Cardio-vascular disease	
	DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-1, 1931, *to* 2-10, 1949, *that I last saw the deceased alive on* 2-10, 1949 *and that death occurred at* 4:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
K.W. Colley (Acting Coroners) M. D.	5103 Harford Rd.	2-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-12-49	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 12 1949		Leonard J. Ruck, 5305 Harford Road.

VS 150

937

correct age is especial important. Physician please write the cause of death clearly and legibly.

G71490 JL- 126754 (2)

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420 Registered No. G71490

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret Cole

2. DATE OF DEATH Feb. 9, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 164 Riverside Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Married	April 8, 1897	51				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME Lou Wegner

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		B. C. H. Records,	4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

16.

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 9, 1949 *to* Feb. 9, 1949 *that I last saw the deceased alive on* Feb. 9, 1949, *and that death occurred at* 9PM *m., from the causes and on the date stated above.*

23A. SIGNATURE	M. D.	23B. ADDRESS	23C. DATE SIGNED
C. L. Rogers		B. C. H. 4940 Eastern Ave.	Feb. 10, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/12/49	Oak Lawn	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 12 1949		John H. Connelly	Essex 24 Md.

VS 150

94a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71491 ✓ 154 (G71491

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Seppi (Joseph Jeppi)
2. DATE OF DEATH: Feb 10/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp Inc.
c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5 or
D. STREET ADDRESS (If rural, give location): 444 N Bay (444 N. Gay Street)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
M	W	Married	Aug 13, 1888	60	5 28	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tavern Keeper	Tavern	Md.	

13. FATHER'S NAME: John Seppi
14. MOTHER'S MAIDEN NAME: Concetta Scutto

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
None		?		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peripheral Vascular Collapse
DUE TO
(B) Coronary Thrombosis
DUE TO
(C) Carcinoma, Rectum

INTERVAL BETWEEN ONSET AND DEATH: 16 hr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Abdominal Perineal Resection

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Feb 5/49	Ca Rectum	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JAN 29, 1949 *to* Feb 10, 1949, *that I last saw the deceased alive on* Feb 10, 1949, *and that death occurred at* 8:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph L. Aponte APONTE M. D.	Mercy Hospital	2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-14-49	Most Holy Redeemer	Belair Rd. Balto: Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 12 1949	[illegible]	George J. Ruth, Inc.	1735 Harford Avenue

VS 150

469

Please write the cause of death clearly and legibly. Physician's important. Exact age is especially

G71492

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 G71492
Registered No.

1. NAME OF DECEASED (Type or Print) JOHN VIVIAN STEWART

2. DATE OF DEATH Feb. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wyman Pk. Drive & 31st St. U.S. Marine Hospital
c. Length of stay in Baltimore 45? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1021 Poplar Grove St. 16 16

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	Sept. 11, 1893	55	4	30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Receiving clerk	Dept. Store	Benedict, Md.	USA

13. FATHER'S NAME: John Ed. Stewart
14. MOTHER'S MAIDEN NAME: Eva Gourley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	WW I	Yes- ?	Records- US Marine Hospital	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Cerebral hemorrhage	7 hrs.?
	DUE TO		
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)		
	DUE TO		
	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT			

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 10, 1949 *to* Feb. 10, 1949, *that I last saw the deceased alive on* Feb. 10, 1949, *and that death occurred at* 6:55P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Jr. M.D. Per Rec'd L. Wilson Clinical Director	US Marine Hospital, Balto, Md.	2/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-15-49	Balto National	Balto Md -

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 12 1949	[illegible]	Thomas J. Kenny Inc	Holbrus & Gilmor 824

VS 150

Correct age is especially important. Physician please write the cause of death clearly and legibly.

071493

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.2 071493

Registered No.

1. NAME OF DECEASED (Type or Print): Inez Stewart

2. DATE OF DEATH: 11 Feb. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1105 N. Gilmor St.
C. Length of stay in Baltimore: 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 105 N. Gilmor St.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 4, 1909
9. AGE (In years last birthday): 39
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chesterfield S. C.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Charlie McLeod
14. MOTHER'S MAIDEN NAME: Dovey Chapman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Alexander Stewart ADDRESS: Wadesboro, N. C.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Embolus — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Chronic Non-Specific Myocarditis — 6 mos.

DUE TO with previous embolic phenomena.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer, D. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 12 Feb. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 14, 1949
24C. NAME OF CEMETERY OR CREMATORY: Wadesboro Cem.
24D. LOCATION (City, town, or county) (State): Wadesboro, N. C.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 12 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Geo. D. Nelson ADDRESS: 303 Lanvale St.

VS 151

939

G71494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71494

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES ALEC RICHARDSON

2. DATE OF DEATH February 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 509 Ensor Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	colored	single	Feb. 15, 1922	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer		Maryland	

13. FATHER'S NAME: Charles Alec Woods

14. MOTHER'S MAIDEN NAME: Sadie Richardson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Elizabeth Barnes	947 Forrest Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute alcoholism	
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil Beyer M.D.		February 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/15/49	Bethlehem National	Frederick Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 12 1949		Joseph E. Locke, Jr.	1304 N. Central Ave

VS 151

77c

G71495

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1 G71495

Registered No.

1. NAME OF DECEASED (Type or Print) CORNELIUS W. STOLK

2. DATE OF DEATH February 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland S. B. Gen. Hos.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.

c. Length of stay in Baltimore 18 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1230 W. North Ave. 13-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	May 30, 1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mess Manne	Mess Manne	Holland	U.S.

13. FATHER'S NAME Cornelius Stolk

14. MOTHER'S MAIDEN NAME Madeline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
World War I		Cornelius A. Stolk	Hawthorne Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George G. Merrill M.D.		2/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feby. 14/49	General Washington Mem. Park	Paramus N. J.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949		John O Mitchell Hoss.	1900 Eutaw Pl

VS 151

94a

PLEASE WRITE PLAINLY, with pen and ink. Physician please write the cause of death clearly and legibly. Correct age is especially important.

To be approved by Medical Examiner

E 902.0
N 821.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71496

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lula K. Byrd
2. DATE OF DEATH: 2-10-49
3. PLACE OF DEATH: A. Baltimore City, Maryland / Church Home
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto - 17 Md
c. Length of stay in Baltimore: Yrs. 50 Mos. Days
D. STREET ADDRESS (If rural, give location): 315 Dolphin 11-04
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 4-13-1878
9. AGE (In years last birthday) / If Under 1 Year: Months Days / If Under 24 Hours: Hours Min.: 27
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H W
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: A. Jackson Taylor
14. MOTHER'S MAIDEN NAME: Hettie Parks
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT / ADDRESS: Wessells, Peggy 315 Dolphin St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia Lobar — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Fracture Rt Femor — 11 3 days

DUE TO

(C) CERTIFICATION APPROVED BY A.G. Merrill M.D. For Wm. H. Kammer, M.D. CHIEF OR ASST. MEDICAL EXAMINER

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 10-22
19B. MAJOR FINDINGS OF OPERATION: Intra Medullary Nailing Rt Femur
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 315 Dolphin St
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: 10-20-48 5 p.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Fell From 3rd Story Window

22. *I hereby certify that I attended the deceased from* 10-21, 1948 *to* 2-10, 1949 *that I last saw the deceased alive on* 2-10, 1949, *and that death occurred at* 2 25 *m., from the causes and on the date stated above.*

23A. SIGNATURE: William R. Best M.D.
23B. ADDRESS: Church Home & Hosp
23C. DATE SIGNED: 10-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-14-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): 3801 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: FEB 12 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR / ADDRESS: John O. Mitchell Sons 1900 Eutaw Place

VS 150

186a

Please write the cause of death clearly and legibly. Physician please write the cause of death clearly and legibly. Physician please write the cause of death clearly and legibly. Physician

G71497 ✓ 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No. G71497

1. NAME OF DECEASED (Type or Print) HENRIETTA F. FORMAN.

2. DATE OF DEATH 2/10/1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 3210 Dorchester Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 60 Yrs. Mos. Dys.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3210 Dorchester Road.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Widow	10/16/ 1877.	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Germany.	U.S.A.

13. FATHER'S NAME Frederick Frank

14. MOTHER'S MAIDEN NAME Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	None	Mr. Leonard Forman	3210 Dorchester Road.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Sclerosis — years
DUE TO

(C) Arterio-Sclerosis - generalized — years.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 1944 *to* Feb. 10 1949, *that I last saw the deceased alive on* Feb. 3 1949, *and that death occurred at* 9P. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry M. Hamman M.D.	20 East Preston St.	2/11/1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/13/1949.	Baltimore Hebrew	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 13 1949	[illegible]	David Lanasman & Son	1902 Eutaw Place.

VS 150

94a

G71498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 903.7 G71498

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FREYER Ida. N-821.0

2. DATE OF DEATH: February 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 45 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: P.G. Prince Geo.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hyattsville
D. STREET ADDRESS (If rural, give location): Mother Jones Rest Home

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W			83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD	

13. FATHER'S NAME: John Eckert.

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	PULMONARY EMBOLUS (EMBOLISM)	1 hr.
DUE TO (B)		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	FRACTURE, FEMUR	2 mos.

CERTIFICATION APPROVED BY

[signature] M. D.

CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Mother Jones Rest Home	Mother Jones Rest Home, Hyattsville, Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Dec. 28, 1948 7 P m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Lost balance and fell to floor

22. *I hereby certify that I attended the deceased from* Feb 1 19 49 to Feb 11, 19 49 *that I last saw the deceased alive on* Feb 11, 19 49, *and that death occurred at* 8 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph Shea M. D.	Univ. Hospital	2/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Lincoln	Colmar Manor Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
FEB 15 1949	[illegible]	J. Hasselbach & Sons Hyattsville Md.

186a

Please write the cause of death clearly and legibly. Physician's signature is especially important. Physician's office address and telephone number must be given. Exact age is especially important.

G71499 ✓ 200.1 G71499

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71499

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FREDERICK WILLIAM KARSTAEDT

2. DATE OF DEATH: Feb. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Marine Hospital, Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 16 S. Smallwood St.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Single	11/27/89	70	2	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Md.	USA

13. FATHER'S NAME: Arnold Karstaedt

14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	WW I		Records- US Marine Hospital	Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Lymphosarcoma with widespread	Unknown
DUE TO	metastases.	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Atrophy of left occipital lobe of brain	Unknown

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 2, 1949 *to* Feb. 11, 1949, *that I last saw the deceased alive on* Feb. 11, 1949, *and that death occurred at* 1:40P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Stuart W. Sessoms M. D.	U.S. Marine Hospital	Feb 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 15, 1949	Balto. National	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 13 1949	[illegible] Washington [illegible], Md.	George L. Schwab	2101 Frederick Ave.

VS 150

55E

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 331 G71500

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anna M. Jones

2 DATE OF DEATH Feb. 12, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 5615 Carter Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ✓

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Queen Anne
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chester
D. STREET ADDRESS (If rural, give location) Md

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Widow	Oct 15-1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Wife

10B. KIND OF BUSINESS OR INDUSTRY ✓

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Jones

14. MOTHER'S MAIDEN NAME Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Miss Bertha Jones ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — many years.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 8, 1949 *to* Feb. 12, 1949, *that I last saw the deceased alive on* Feb 12, 1949, *and that death occurred at* 9:28 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Max R. English M. D.

23B. ADDRESS 5713 Belair Rd Balt 6, Md.

23C. DATE SIGNED 2-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 2-16-49

24C. NAME OF CEMETERY OR CREMATORY Stevensville

24D. LOCATION (City, town or county) Stevensville (State) Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 13 1949

REGISTRAR'S SIGNATURE Washington Hathaway, M.D.

25. FUNERAL DIRECTOR Edgar L Lem Church Hill ADDRESS Md

83a

PLEASE WRITE PLAINLY, WITH INK OR INDELIBLE PENCIL. Erasures or alterations must be explained or initialed by person making them. Be sure to answer every question. Be correct and complete in giving date of death clearly and fully. Be correct as to age is especially important. Physician please write the cause of death clearly and fully.

G71501 ✓ 151 G71501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRY SIGEL

2. DATE OF DEATH: 2-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4602 Pimlico Road
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4602 Pimlico Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 72 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Israel
14. MOTHER'S MAIDEN NAME: Frieda
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Rose Sigel — ADDRESS: 4602 Pimlico Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Carcinoma of the Stomach

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1947 *to* Feb 12 , 1949 *that I last saw the deceased alive on* Feb 12 1949 *, and that death occurred at* 10:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Herbert L. Kolman M. D.
23B. ADDRESS: 3700 York (Hospital)
23C. DATE SIGNED: Feb 12 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-13-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Dalto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Jack Lewis Inc — ADDRESS: 2100 Eutaw Pl

VS 150 1948

46K

G71502 ✓ 452 G71502

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): David Rosenberg

2. DATE OF DEATH: 2-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2610 E. Chase St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	married		54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman		Baltimore Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel	Ann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	World War I		Bessie Rosenberg	2610 E Chase St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage,
DUE TO due to ruptured
(B) aneurysm of circle of Willis.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ✓, *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George L. Merrill M.D.	✓	2-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	2-13-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 13 1949	[illegible]	Jack Lewis Inc	2100 Eutaw Pl

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physician please write the cause of death exactly as he would have it entered on his records. Be sure to correct age is especially important.

83a

G71503 ✓ 420.1 03

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No. G71503

1. NAME OF DECEASED (Type or Print) Hyman Adler

2. DATE OF DEATH Feb 11 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore MD

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

C. Length of stay in Baltimore 40 yr. Yrs. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1126 E Baltimore St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	white	divorced		54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman Tailors		Russia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lucius David Adler	Riva Bala

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Max Adler	2100 E Lombard St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary occlusion	48 hrs
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Coronary Heart Disease	10 yrs
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Benign hypertrophy of prostate	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Feb 8, 1949	Benign hypertrophy of Prostate	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 29, 1949 *to* Feb 11, 1949 *that I last saw the deceased alive on* Feb 11, 1949 *and that death occurred at* 6·30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis H. Jaffe M. D.	Sinai Hospital	Feb 11 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-13-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
	Cunningham / Registrar	Jack Lewis Inc	2100 Eastern Pl

PLEASE WRITE PLAINLY, with ... correct age is especially important. Physician: please write the cause of death clearly.

FEB 1 1949 VS 350

✓ 127a

G71504

334 G71504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Ida Cohen

2. DATE OF DEATH: 2-12-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3602 Lucille Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 75 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY: ✓

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Paul Cohen ADDRESS: 2001 W Lanvale St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hemiplegia

DUE TO

(C) Cerebral arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2 - 9, 1949 *to* 2 - 12 -, 1949 *that I last saw the deceased alive on* 2 - 12 - 1949 *and that death occurred at* 10 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jerome J. Blumberg M. D.
23B. ADDRESS: Levindale Home
23C. DATE SIGNED: 2-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-13-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 13 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

PLEASE WRITE PLAINLY, with pencil or pen. Physician please write the cause of death correctly. Correct age is especially important.

839

G71505

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

414 G71505

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Earl J. Higdon

2. DATE OF DEATH: Feb 12 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Redwood + Hanover St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: 32 years. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1819 Westphal Place

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 21-1916
9. AGE (In years last birthday): 32 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glass Stopper Cutter
10B. KIND OF BUSINESS OR INDUSTRY: Glass Bottles
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Harry Higdon
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 217-09-4101
17. INFORMANT: Mrs. Helen Schwarz 1819 Westphal Pl. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Sub Acute Bacterial Endocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO: Rheumatic Heart Disease

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hepatitis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 11, 1949 to Feb 12, 1949 that I last saw the deceased alive on Feb 12, 1949 and that death occurred at 12 35 A.M., from the causes and on the date stated above.

23A. SIGNATURE: Frank E Brumback M. D.
23B. ADDRESS: University Hosp. Lot
23C. DATE SIGNED: 2/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 15-1949
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn 9-9-6 Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15
REGISTRAR'S SIGNATURE: Courtesy for Williams, MD
25. FUNERAL DIRECTOR: Geo. L Berger Jr
ADDRESS: 1512 Hollins St

VS 150

95R

PLEASE WRITE PLAINLY with pen or pencil; please write the cause of death in ... correct age is especially important. Physician

G71506 ✓ 420.1 G71506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): AMELIA J. STARR

2. DATE OF DEATH: 2/10/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2315 E Federal

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

C. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 2315 E Federal St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F.	W	WIDOW	JULY 2. 1863	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BORING Md.
12. CITIZEN OF WHAT COUNTRY? —
13. FATHER'S NAME: THEODORE GILL
14. MOTHER'S MAIDEN NAME: SCHAEFFER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion — Interval between onset and death: 7 hrs.
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Arteriosclerosis — 4 yrs.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1947 *to* Feb 10, 1949 *that I last saw the deceased alive on* Feb 10, 1949 *and that death occurred at* 1.45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: L W Ruter M. D.
23B. ADDRESS: 1706 N Wash. St
23C. DATE SIGNED: 2/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: FEB. 14, 49
24C. NAME OF CEMETERY OR CREMATORY: BALTO Cem.
24D. LOCATION (City, town, or county) (State): BALTO.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Covington for Whitehurst
25. FUNERAL DIRECTOR: L. HECHMANN
ADDRESS: 6067 HARFORD Rd

PLEASE WRITE PLAINLY. Physician: please write the cause of death correct age is especially important.

VS 150

94a

G71507 ✓ 420.0 G71507

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): AUGUST FRANK KOZLOVSKY
2. DATE OF DEATH: Feb. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hosp.
C. Length of stay in Baltimore: 64, 29 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2116 Ashland Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
M	W	Married	12/13/84	64	1	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Maryland	U.S.

13. FATHER'S NAME: Joseph Kozlovsky
14. MOTHER'S MAIDEN NAME: Anna Wisniewsky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. F. Kozlovsky ADDRESS: 2116 Ashland Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Coronary Thrombosis
DUE TO
(B) Arterio-sclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 2, 1949 to Feb 11, 1949 that I last saw the deceased alive on Feb 11, 1949 and that death occurred at 2:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE: Raul Persons M.D.
23B. ADDRESS: St. Josephs Hosp.
23C. DATE SIGNED: 2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Buried	Feb 14/49	Holy Redeemer	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jerome Coach ADDRESS: 900 N. Chester

VS 150

937

PLEASE WRITE PLAINLY. Physician, please write the cause of death correctly. Accurate and complete information is especially important.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

422.1 G71508

BIRTH NO. G71508 — Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPHINE KORTA
2. DATE OF DEATH: 2/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — St. Joseph's Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — E 04
D. STREET ADDRESS (If rural, give location): 2209 Prentiss Place

c. Length of stay in Baltimore: 55 (Yrs.)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Joseph Benedict
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service
16. SOCIAL SECURITY NO.
17. INFORMANT: Anna Klyer — ADDRESS: 2230 Hennemans

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: John R Waers M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR X
23C. DATE SIGNED: 2/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	Feb. 14/49	Holy Redeemer	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: FEB 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR — ADDRESS: Jerome Coach 900 N. Chester

VS 151

PLEASE WRITE PLAINLY, WITH INK. Be sure to give correct age in years, and if under 1 year, months, days, hours or minutes, as the case may be. Physician please write the cause of death in terms which are especially important.

93D

G71509 ✓ 422.1 G71509

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM WALTER HOWARD.

2. DATE OF DEATH: Feb 10 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6412 Rosemont Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): -

c. Length of stay in Baltimore: 46 Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6412 Rosemont Ave. 7-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	married	Oct. 27 - 1872	76	3	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Calvert Co Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John W. Howard.
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Ritchie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: 216-12-5381
17. INFORMANT: Victoria Howard - ADDRESS: 6412 Rosemont Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Organic Heart Disease	unknown
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Influenza	10 days
DUE TO		
(C)	Arteriosclerosis	unknown
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 15 - 1944, *to* February 19 1949 *that I last saw the deceased alive on* Feb 9 - 1949, *and that death occurred at* 11.25 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Chester Riland, M. D.
23B. ADDRESS: 2532 Edmondson Ave
23C. DATE SIGNED: 2-11-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/14/49	Parkwood Cemetery	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1949
REGISTRAR'S SIGNATURE: Huntington Wilkerson, Asst
25 FUNERAL DIRECTOR: WM. J. TICKNER & SONS INC.
ADDRESS: North & Fa. Aves Balto. 17, Md.

PLEASE WRITE PLAINLY. Physician please write the cause of death in such terms as will convey to the undertaker and to the registrar the correct age is especially important.

95c

✓ 420.0 G71510

G71510

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): KATE A. GUNDERSDORF

2. DATE OF DEATH: Feb. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5301 Wayne Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimor
D. STREET ADDRESS (If rural, give location): 5301 Wayne Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Single	Sept. 30, 1864	84	4	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Seamstress	-	Baltimore, Md.	USA

13. FATHER'S NAME: Christian Gundersdorf

14. MOTHER'S MAIDEN NAME: Sophia (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	?	Mr. S. C Gundersdorf	1200 Lakeside Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Thrombosis	one hour
DUE TO	arteriosclerotic type heart disease	many years
(B)	with Cardiac hypertrophy and Dyspnea	
DUE TO	tension	
(C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January, 1935 *to* Feb 12, 1949 *that I last saw the deceased alive on* June 31, 1949, *and that death occurred at* 6 30A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm Nichols M. D.	2901 Hunsdon Rd	Feb 12 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/14/49	Loudon Park Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Wilkerson, M.D.	WM. J. TICKNER & SONS INC.	North & Fa. Aves Balto. 17, Md.

PLEASE WRITE PLAINLY, with pencil or pen, please write the cause of death correct age is especially important. Physician

931

G71511 ✓ 527.1 G71511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH K. KNELL

2. DATE OF DEATH: Feb. 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1216 Bloomingdale Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1216 Bloomingdale Rd.

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Dec. 15, 1878	70 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Butter & Egg Dealer(rtd)	Self	Baltimore, Md.	

13. FATHER'S NAME: Charles Knell

14. MOTHER'S MAIDEN NAME: Mary Ellen Airey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes — Spanish American		Mrs. F. Edith Knell	1216 Bloomingdale Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Chronic Myocarditis	6 mos.
DUE TO (B)	Pulmonary Emphysema	5 yrs.
DUE TO (C)	Paralysis, vocal cords	1 yr.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1948 *to* 11 Feb 1949, *that I last saw the deceased alive on* 9 Feb, 1949, *and that death occurred at* 11:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. H. Kammer Jr. M.D.	501 Sheridan Ave.	12 Feb. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/14/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 13 1949	[illegible]	WM. J. TICKNER & SONS	Balto., Md.

FEB 150

PLEASE WRITE PLAINLY, with ink. Physician: please write the cause of death in such terms as will convey to others the correct idea of the disease or casualty. Be sure to fill correct age is especially important.

927

G71512 ✓ 443 G71512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): SOPHIE STRACKE
2. DATE OF DEATH: FEB 10 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 16 S CASTLE ST.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 16 S CASTLE ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
FEMALE	WHITE	WIDOWED	OCT 13 1865	83	3	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH GILLEY
14. MOTHER'S MAIDEN NAME: HELEN ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: NONE
17. INFORMANT: GEORGE STRACKE ADDRESS: 16 S CASTLE ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Cardio-Vascular Hypertensive Disease — 10 years
DUE TO
(C) Arteriosclerosis — 10 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 6, 1942, *to* Feb, 10, 1949, *that I last saw the deceased alive on* Feb, 9, 1949, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Michael J. Dausch M. D.
23B. ADDRESS: 1 W. Chesterfield Ave
23C. DATE SIGNED: 2/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	FEB 14 1949	HOLY REDEEMER	4430 BELAIR ROAD MD

DATE RECEIVED BY LOCAL REGISTRAR: FEB 13 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Diffel Bros ADDRESS: 800 E Lombard St

VS 150

PLEASE WRITE PLAINLY ... correct age is especially important. Physician: please write the cause ... of death

93 D

442 ✓ G71513

G71513

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Francis William Truelove

2. DATE OF DEATH: Feb. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1122 Ensor St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1122 Ensor St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Oct. 19, 1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cable Inspector	City	Baltimore	U. S.

13. FATHER'S NAME: George R. Truelove

14. MOTHER'S MAIDEN NAME: Mary Jane Manning

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No	-	Mrs. Catherine Truelove 1122 EnsorSt

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	1 week
DUE TO	Cardio - vascular - renal disease	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
(C)		over
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	? ~~[illegible]~~ ~~[illegible]~~ (~~[illegible]~~ ~~test~~)	1day

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 19~~48~~, *to* Feb. 10, 1949, *that I last saw the deceased alive on* Feb. 10, 1949, *and that death occurred at* 7:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. Felsenfeld M. D.	714 E. Preston St	12 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 14/49	Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 13 1949	Huntington Williams, M.D.	Rita Wiedefeld, 900 E. Biddle St

VS 150

PLEASE WRITE PLAINLY, correct age is especially important. Physician: please write the cause

121a

G71514 ✓ 420 D G71514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES HALEY

2. DATE OF DEATH Feb 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

C. Length of stay in Baltimore 25 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 700 E Lexington St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	W	Divorced	March 7, 1886	63 62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cooksman		Canada	

13. FATHER'S NAME James Haley

14. MOTHER'S MAIDEN NAME Emma

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2-3-49 (?)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic degenerative [illegible] — several years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 2, 19 49 *to* Feb 11, 19 49, *that I last saw the deceased alive on* Feb 10, 19 49, *and that death occurred at* 5 25 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John M Buckingham M. D.	Mercy Hosp	Feb 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-14-49	Loudon Park	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 13 1949		Wiedefeld & Son 6 Greenmount & 22nd

PLEASE WRITE PLAINLY, with pencil or pen, and please write the name of the informant. Physician, please write the cause of death correctly. Age is especially important.

Lexington Williams, M.D.

93 D

BIRTH NO. G71515

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 G71515 Registered No.

1. NAME OF DECEASED (Type or Print): IVAN BROWN

2. DATE OF DEATH: February 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Penitentiary

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10 c 3
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	C	M	12/26/1908	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	—	Southampton Co. Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Willie Brown	Emma Artis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
—		W. M. Johnson - Husband Franklin Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage, Hypertension

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X] *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: Earl L Rayer M.D

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Feb. 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-16-49	Mt. Tabor	Franklin Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
FEB 13 1949	Acting for Williams, M.D.	Wm. V. Chatman Jr. - Balto. City

VS 151

83a

PLEASE WRITE PLAINLY. Physician: please write the cause of death so that a correct age is especially important.

G71516 — 334 — G71516

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Milford C. Lehman
2. DATE OF DEATH: Feb. 10, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland — 4506 Sorrento Ave
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Md. B. COUNTY: Balto.
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Colonial Nursing Home
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
c. Length of stay in Baltimore: Yrs. 2 Mos. 6 Days
D. STREET ADDRESS (If rural, give location): 6218 Alamore Way
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept 2, 1899
9. AGE (In years last birthday): 49 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Food Products
11. BIRTHPLACE (State or foreign country): Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Lehman
14. MOTHER'S MAIDEN NAME: Daisy Green
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 219-10479
17. INFORMANT: Mrs Carolyn V. Lehman — ADDRESS: 6218 Alamore Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pulmonary Edema	12 hours
DUE TO	Hypertension	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Hemiplegia, right	12-1-48
DUE TO	Hypertension	
(C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-6, 1949 *to* 2-10, 1949 *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: William L. Fearing M. D. | 23B. ADDRESS: 3025 Belair Road | 23C. DATE SIGNED: 2-12 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 2/14/49 | 24C. NAME OF CEMETERY OR CREMATORY: Baltimore | 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 13 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Loring Byers | ADDRESS: 5005 Pk Heights Ave

837

Please write plainly. Important. Physician, please fill in all items. Correct age is especially important.

71517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 71517

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Clara Bowie

2 DATE OF DEATH: FEB 13 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md. B COUNTY: Charles
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Marbury
D STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Widowed	9-1-1886	62		

10A. USUAL OCCUPATION (Give kind of work done during greatest working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife		Md	

13. FATHER'S NAME: Thomas Davis

14 MOTHER'S MAIDEN NAME: India Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17 INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) CARCINOMA of STOMACH	3yrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO METASTATIC TO PERITONEUM	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Hypertension	4 yrs

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
8 Feb 1949	Metastatic Carcinoma	YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) JOHNS HOPKINS HOSPITAL

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-29-, 1949, *to* 2-13, 1949, *that I last saw the deceased alive on* 2-13, 1949, *and that death occurred at* 2:10 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Richard S Ross M.D	Johns Hopkins Hospital	13 Feb 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Feb 16 49		Marbury Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Thomas F Hayes	Marbury Md.

VS 150

462

Important. Physician: please write ... Correct age is especially ...

71518 — 1 — ✓ 446 — G71518

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MAZIE DELLA VOLLMER

2. DATE OF DEATH: 2/11/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland 1511 N. Potomac St.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1511 N. Potomac St.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: May 14, 1878
9. AGE (In years last birthday): 70 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jesse Finster
14. MOTHER'S MAIDEN NAME: Sarah Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT — ADDRESS: Mr. Harry Vollmer, 1511 N. Potomac

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension vascular renal disease — Interval between onset and death: 1 yr +

DUE TO

(C) Overweight.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 10, 1948, *to* Feb 11, 1949, *that I last saw the deceased alive on* Feb 11, 1949, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. D. Lyday, M. D.
23B. ADDRESS: 432 S Patterson Pk Bo
23C. DATE SIGNED: 2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/14/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND 13/a

71519 V-334 G71519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) William Miller.

2. DATE OF DEATH Feb. 12, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1808 E. North Ave.
c. Length of stay in Baltimore 90 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md
D. STREET ADDRESS (If rural, give location) 1808 E North Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	W.	Widower	NOV. 7 1858	90 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired.
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Balto. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Peter Miller.
14 MOTHER'S MAIDEN NAME — Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Mrs. Sophie A. Recktenwald ADDRESS Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebro vascular accident	3 weeks
DUE TO (B)	Old Age.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Bowel OBSTRUCTION	

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 11, 1949 *to* Feb 12, 1949 *that I last saw the deceased alive on* Feb 11, 1949 *and that death occurred at* 10:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE Maurice Follmer M. D.
23B ADDRESS 1437 N Kenwood Ave
23C DATE SIGNED Feb. 14 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Feb. 15. 1949
24C. NAME OF CEMETERY OR CREMATORY Trinity Cemetery
24D LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 14 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC. Baltimore Md.

VS 150

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71520 ✓178 G71520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) GEORGE EDWIN BRAUER

2. DATE OF DEATH Feb. 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) AT HOME 2038 E. North Ave.

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2038 E. North Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 1 Day: Hours	Min.
M	W	Married	11/12/22	26	3	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman

10B. KIND OF BUSINESS OR INDUSTRY Pepsi Cola Co.

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John H. Brauer

14. MOTHER'S MAIDEN NAME Myrtle Marie Hyman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW 2

16. SOCIAL SECURITY NO 217-16-7301

17. INFORMANT Mrs. Marilyn A. Brauer ADDRESS 2038 E. North Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO Teratocarcinoma, right testicle with widespread metastasis	Unknown
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION 2 March 1948 | 19B. MAJOR FINDINGS OF OPERATION Glandular metastasis to abdomen. | 20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 20 Feb 1948 *to* Feb. 11, 1949, *that I last saw the deceased alive on* Feb. 11 1949, *and that death occurred at* 8:15 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE Wm. H. Kammer M.D. 23B. ADDRESS 501 Sheridan Ave. 23C. DATE SIGNED 12 Feb. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/14/49	Baltimore Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR FEB 14 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25 FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND 51C

✓ 420.1

671521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

671521 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Bessie Snyder

2. DATE OF DEATH February 13, 19

3. PLACE OF DEATH: A. Baltimore City, Maryland 145 N Front St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 45 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) 49
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 145 N Front St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife		Russia	

13. FATHER'S NAME Harry Pomerantz

14. MOTHER'S MAIDEN NAME Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Dena Dannenberg	3525 Wabash Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

(B) Artio Sclrosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 19 48 *to* Feb 13, 19 49 *that I last saw the deceased alive on* Feb 10, 1949, *and that death occurred at* 4:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Kadrn M. D.	2306 Eutaw Pl	2-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 14/49	Hebrew Rivedale	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Sol Levinson & Bro	North ave

VS 15D

94a

G71522 ✓153 G71522

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Ella C. Snyder

2. DATE OF DEATH: Feb. 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1322 Aisquith St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1322 Aisquith St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1322 Aisquith St. 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	April 20, 1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME: James E McNamee

14. MOTHER'S MAIDEN NAME: Catherine Almony

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		213-03-5012	James . Snyder	4221 old Frederick St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Broncho Pneumonia	3 days
	DUE TO	Erysipelas	3 days
ANTECEDENT CAUSES		arteriosclerosis	1 yr
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	Emphysema Heart with Myocarditis	1 yr
	DUE TO	Chronic Interstitial Nephritis	4 yr
	(C)	Carcinoma Sigmoid	2 mo
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		Chronic Arthritis	30 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 11 19 49 *to* Feb 11 19 49, *that I last saw the deceased alive on* Feb 11 19 49 *and that death occurred at* 11 30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
I F A Stevens M. D.	2818 Harford Rd	2-12-49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	2/15/49	Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Wm Cook Inc.	127 St. Paul St.

VS 150

46E

✓ 4423

BIRTH NO. 71523

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71523

1. NAME OF DECEASED (Type or Print): Martha G. Hutton

2. DATE OF DEATH: 12 Feb. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital (D.O.A.)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): St. James Apt. - Chas & Centre sts 11-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Feb 6th 1878	71	0	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	Self	North East Md	U.S.A.

13. FATHER'S NAME: David A. Drew

14. MOTHER'S MAIDEN NAME: Elizabeth M. Gifford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: OR P.O. Mrs. Edwin Tunis, Reisterstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: ? ?

DUE TO

(B) Hypertensive Cardio-Vascular Disease — 2 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 12 Feb. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	2/16/49	Arlington (Lansdowne)	Philadelphia Pa.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. Cook Inc. ADDRESS: 1217 St. Paul st.

VS 151

93

PLEASE WRITE AND correct age is especially important. Physician: please write the cause

G71524

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G71524

1. NAME OF DECEASED (Type or Print): Anna Leonard

2. DATE OF DEATH: Feb. 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Jenkinds Mem. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland — B. COUNTY: Baltimore — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville, Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jenkin's Memorial Hospital

c. Length of stay in Baltimore: 22 (Yrs. / Mos. / Days)

D. STREET ADDRESS (If rural, give location): 66 Prospect Ave., Catonsville Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	6/29/76	72 72	7	14

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	None	Texas, Maryland	USA

13. FATHER'S NAME: Patrick Keough

14. MOTHER'S MAIDEN NAME: Ellen Mannion

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Family	66 Prospect Ave., Balt. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio - Reff. failure.

DUE TO

(B) Uremia

DUE TO

(C) Degenerative Arteriosclerotic C-V Dis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 15 *, 19*49 *, to* Feb. 13 *, 19*49 *, that I last saw the deceased alive on* Feb. 12 *, 19*49 *and that death occurred at* 3:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Isaac E. Carr Jr. M. D.	St Agnes Hosp.	2/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/16/49	St. Josephs	Texas Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 150

937

Please print. Physician: Please be sure that correct age is especially important. Physician: please be sure that correct age is especially important.

G71525

581.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71525

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BERTHA J. GREEN

2. DATE OF DEATH: 2/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural give location): 3119 Brighton Pl 2801

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	M	12/23/83	65	1 / 17	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper		Md	

13. FATHER'S NAME: Thomas Summers

14. MOTHER'S MAIDEN NAME: Margaret Weaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cirrhosis of liver	?
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Auricular fibrillation	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/6 19 49 *to* 2/10 19 49 *that I last saw the deceased alive on* 2/10 19 49 *and that death occurred at* 10 1/2 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles J. Blazek M. D.	Maryland General	2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 14 1949	Lorraine Park	Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Roland L. Fisher, Dundalk, Md.

VS 150

1248

Physician: please write plainly. Important. Please correct age is especially important.

✓ 443

G71526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71526

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): MAGDALINE (MAGDALINA) MYERS

2. DATE OF DEATH: Feb. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1214 SARGEANT St.
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2114 SARGEANT St. 7-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
FEMALE	White	MARRIED	SEPT. 6, 1879	69	5 6	- -

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	MARYLAND	U.S.A.

13. FATHER'S NAME: John W. HENKEL

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No.		

17. INFORMANT: THELMA ODENSOS ADDRESS: 2114 SARGEANT St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteriosclerotic cardio vascular disease	6 mons
DUE TO (B)	Hypertension	6 mons
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	none	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give street location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug. 2, 1948 *to* Feb 12, 1949 *that I last saw the deceased alive on* Feb 12, 1949 *and that death occurred at* 6:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Miller M.D.	2030 Wilkens Ave	2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	Feb. 15, 1949	CEDAR HILL	A.A. County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams M.D.	GEORGE L. SCHWAB	2101 FREDERICK AVE.

VS 150

937

Correct age is especially important. Payment...

71527 ✓ 581,0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No. G71527

1. NAME OF DECEASED (Type or Print): Susan M. Cotter McCOMAS
2. DATE OF DEATH: 2-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: 61 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 663 Gutman Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Married	2-22-85	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia (Jamestown)
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Patrick Cotter
14. MOTHER'S MAIDEN NAME: Susan Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO
0	0	

17. INFORMANT: William McComas ADDRESS: 663 Gutman Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hemorrhage, Esophageal Varix
DUE TO
(B) Cirrhosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pernicious Anemia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 12, 1949 *to* Feb 13, 1949, *that I last saw the deceased alive on* Feb 13, 1949, *and that death occurred at* 2:25 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. F. Cotter M.D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 2-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/16/49	New Cathedral Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

1246

Street age is especially important. Physician: please write out.

71528 V 76 2.5 G71528

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-02182 Registered No.

1. NAME OF DECEASED (Type or Print): MOORE, BABY BOY
2. DATE OF DEATH: 1-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: 1 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Newborn
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto, Md. 15 ot
D STREET ADDRESS (If rural, give location): 828 W. Lanvale St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	S	1-29-49		1	4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
newborn		Balto, Md	

13. FATHER'S NAME: Moore, William
14. MOTHER'S MAIDEN NAME: Clement, Rosena

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure — DUE TO

(B) Atelectasis — DUE TO

(C) Prematurity

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Erythroblastosis fetalis ?

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-30-, 1949, *to* 1-30-, 1949, *that I last saw the deceased alive on* 1-30-, 1949, *and that death occurred at* 10:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W.A. Hermann M.D.	Univ. Hosp.	2-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		University Medical School	FEB 11 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

159

71529 ✓491 (G)71529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 48-27033 Registered No.

1. NAME OF DECEASED (Type or Print): Branson, Baby Boy

2. DATE OF DEATH: 1-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: 58 Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Newborn
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. md.
D STREET ADDRESS (If rural, give location): 508 - Bruns St. 17 K 3

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: 12-5-48
9. AGE (In years last birthday): If Under 1 Year Months Days: 58 / If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): newborn
10B. KIND OF BUSINESS OR INDUSTRY: newborn
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Nathan Grady
14. MOTHER'S MAIDEN NAME: Sarah Branson ✓
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Sarah Branson ADDRESS 508 Bruns St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure
DUE TO
(B) Bronchopneumonia
DUE TO
(C) Prematurity, &c

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22 *I hereby certify that I attended the deceased from* 1-4-, 1949, *to* 1-31-, 1949, *that I last saw the deceased alive on* 1-31-, 1949, *and that death occurred at* 4:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm Harmann M. D.
23B ADDRESS: Univ. Hosp.
23C DATE SIGNED: 2-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: University Medical School FEB. 11 '49
24D LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25 FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 150

107

✓ 386

G71530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G71530

1. NAME OF DECEASED (Type or Print): Mary A. Campbell

2. DATE OF DEATH: 2/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 807 W. Cross St.
c. Length of stay in Baltimore: 6 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 807 W. Cross St. 21-07

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 5/16/1887
9. AGE (In years last birthday): 61 (If under 1 year: Months; If under 1 day: Hours; If under 24 hours: Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel A. McCaffrey
14. MOTHER'S MAIDEN NAME: Mary A. Clarke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
SOCIAL SECURITY NO: —

17. INFORMANT: Mrs Charles A Campbell ADDRESS: 807 W. Cross St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Biliary Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cause undetermined

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.):
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-23, 1949, *to* 2-11, 1949, *that I last saw the deceased alive on* 2-11, 1949, *and that death occurred at* 11:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: John P. Ulevich, Jr. M. D.
23B. ADDRESS: 1227 Wade Blv'd
23C DATE SIGNED: 2-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/15/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D LOCATION (City, town, or county) (State): 4300 Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son ADDRESS: 911 Hollins St.

VS 150

127B

collect age is especial importance

✓ E 1/6/1 N-69.2 X

G71531

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G71531

1. NAME OF DECEASED (Type or Print): LUTHER COFFEY ~~COFFEE~~ jr.

2. DATE OF DEATH: February 12, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: West Virginia
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): North Matewan
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White		1/5/1922	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Soldier	U.S.Army	Cooperative, Kentucky	U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W W II		U.S.Army,	Ft.Geo.G.Meade, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed chest

~~DUE TO~~ (OR) Ruptured liver

DUE TO Massive hemorrhage into abdominal cavity

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Public	U.S. Route #1, Harwood Park, Howard Co. Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
February 12, 1949 12:25 a.m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Auto into trailor truck

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
George L. Merrill M.D.		2-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/15/49	Balto. National	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Turnbington Williams, M.D.	Lilly & Zeiler Inc	403 S. Wolfe Balto 31

VS 151

170 c

G71532 V 590

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G71532

1. NAME OF DECEASED (Type or Print): Catherine Agnes Korzeniewski
2. DATE OF DEATH: Feb. 12, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24
D. STREET ADDRESS (If rural, give location): 1235 S. Packer Ave. 01

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married.
8. DATE OF BIRTH: 1/10/01
9. AGE (In years last birthday): 48 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: LUDOWSKI
14. MOTHER'S MAIDEN NAME: MARY SPORACZ
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr WALTER KORZENIEWSKI — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Hemorrhagic Nephritis.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Obesity + Diabetes Mellitus

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 5 *1949, to* Feb. 12, *1949, that I last saw the deceased alive on* Feb. 12, *1949, and that death occurred at* 11.45 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Philip G. Peter M.D.
23B. ADDRESS: 1400 N. Cowlin St
23C. DATE SIGNED: Feb 12 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/17/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. STANISLAUS CEM
24D. LOCATION (City, town, or county) (State): Dundalk Ave Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: STEVEN J. ZALEWSKI, INC.
ADDRESS: 1000 S. KEYWOOD AVE

VS 150

Correct age is especially important. Physician, please

61

G71533 — 331 — G71533

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. ANNA E. MILLER (ANNIE)

2. DATE OF DEATH: Febr. 13 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1407 Forest Hill

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at Home

C. Length of stay in Baltimore: 4 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE: Md — B. COUNTY: Balto City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

D. STREET ADDRESS (If rural, give location): 1407 Forest Hill Ave.

5. SEX: Female — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: Febr 11, 1867 — 9. AGE (In years last birthday): 82 87 — If Under 1 Year: Months / Days: 2 — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none — 10B. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Frederick Co. Md. — 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: David Plunkert.

14. MOTHER'S MAIDEN NAME: Saranda Stegner.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mrs. Lida Burke - 2619 Maryland Ave. Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cerebral Hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) generalized arteriosclerosis — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-26, 19[illegible], *to* 2-13, 19[illegible], *that I last saw the deceased alive on* 2-[illegible]-49 19[illegible], *and that death occurred at* 9A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. E. Gunkel M. D. — 23B. ADDRESS: 2703 Edmondson Ave — 23C. DATE SIGNED: 2-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: Feb 14/49 — 24C. NAME OF CEMETERY OR CREMATORY: New Freedom — 24D. LOCATION (City, town, or county) (State): New Freedom - Pa.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949 — REGISTRAR'S SIGNATURE: Livingston Williams, M.D. — 25. FUNERAL DIRECTOR — ADDRESS: Harkinderfer Funeral Home New Freedom Pa.

VS 150

Copies are to be typewritten. Improper [illegible]

832

V 420.1

71534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71534

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Ann Smith

2. DATE OF DEATH: Feb 13 49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 618-E-34-St-

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md. B. COUNTY Balto City

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 618-E-34-St. 9 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widow	Feb 24 1875	74 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Balto. Md.	U S

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Cripps	Catherine Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	NONE	Mary V. Callahan	618-E-34 St-

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized arteriosclerosis — ?

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Emaciation — 1 mo.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 4, 1948, *to* Feb 13, 1949, *that I last saw the deceased alive on* Feb 7, 1949, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frederick J. Vollmer M. D.	6100 York Road	Feb 14 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb-16	Mt. Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Stewart Moore & Co.	Balto.

VS 150

94a

collect ago is especially important

HEALTH DEPARTMENT—CITY OF BALTIMORE 671535

671535

CERTIFICATE OF DEATH

1. PLACE OF DEATH
CITY OF BALTIMORE: (No.) 1505-N. Strieker (Ward)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

Registered No. ...
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME William Everett West
If U. S. Veteran specify WAR ...

(a) Residence: No. 1505-N. Strieker St. Ward. 15-01
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. Sex: M
4. Color or Race: Col.
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced BUSBAND of (or) WIFE of Anderson

6. DATE OF BIRTH (month, day, year) 1885

7. AGE: Years 63 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ...
10. Date deceased last worked at this occupation (month and year) ...
11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Balto, Md.

FATHER
13. NAME Thomas Joshua E. West
14. BIRTHPLACE (city or town) (State or country) Balto, Md.

MOTHER
15. MAIDEN NAME Henrietta Bias
16. BIRTHPLACE (city or town) (State or country) Balto, Md

17. INFORMANT William West
(Address) 1505-N. Strieker

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. Calvary Date Feb 16, 1949

19. UNDERTAKER J. Brooks
(Address) 463 N. Carey St

20. FILED FEB 14 1949 Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 2-12-49

22. I HEREBY CERTIFY, That I attended deceased from 1-26-49 to 2-12-49
I last saw ... alive on 2-12-49. Death is said to have occurred on the date above, at 8:30 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
(a) Bronchopneumonia	4 wks
Acute Arteritis	
Other contributory causes of importance:	
Emphysema & Arteritis	

Was an operation performed? ... Date of ...
For what disease or injury? ...
Name of operation ...
What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place ...
Manner of injury ...
Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify ...

(Signed) Jas. R. Blake M. D.
(Address) 1505-N. Carolina

107 2-14-49

This CAUSE OF DEATH and OCCUPATION is very important. See instructions on back of certificate.

V0.3

1536

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E-98-0 N-9612 G71536

Registered No.

1. NAME OF DECEASED (Type or Print): Beatrice Jones

2. DATE OF DEATH: 2-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1105 Clendenin St. 13-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	married	Oct 27-1914	34		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Va	U.S.A

13. FATHER'S NAME: John H Watson

14. MOTHER'S MAIDEN NAME: Alice Eubanks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Julia Pearce ADDRESS: 1633 Ashland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stab Wound of Heart — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1105 Clendenin St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 2 10 49 8:30P.m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Sharp Instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: Emil L Kruger M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 2-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 1949	Edmond Watson Mem.	Ontario Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Robert L Williams	1515 McElderry St

VS 151

167

correct age is especially important. Physicians, please

✓ 010

BIRTH NO. 71537 & copy

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71537

1. NAME OF DECEASED (Type or Print): Benjamin Campbell

2. DATE OF DEATH: February 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1631 Mc Elderry St.

5. SEX: Male
6. COLOR or RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 8-26-99
9. AGE (In years last birthday) If under 1 year: Months / Days; If under 24 hours: Hours / Min.: 49
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: ? Campbell
14. MOTHER'S MAIDEN NAME: Frances Burnett
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculous meningitis — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Disseminated miliary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: weeks 6 months
DUE TO
(C)
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-10 1949 *to* 2-10, 1949 *that I last saw the deceased alive on* 2-10, 1949, *and that death occurred at* 8 15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Anthony J. Dee M. D.
23B ADDRESS: JOHNS HOPKINS HOSPITAL
23C DATE SIGNED: 2-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 16-1949
24C. NAME OF CEMETERY OR CREMATORY: National Cemetery
24D LOCATION (City, town, or county) (State): Bath Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Robert F. Williams ADDRESS: 1515 McElderry St

VS 150

13R

Do not use this space — Reserved for Official Purposes

✓ 420.0

G71538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G71538

1. NAME OF DECEASED (Type or Print) Dominic Rodgers

2 DATE OF DEATH 2-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West 25th St - 424

c. Length of stay in Baltimore 7 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE Maryland B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 424 W [redacted] 25th St

5. SEX	6 COLOR OR RACE	7 ~~SINGLE, MARRIED, WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	S.	11/15/1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Vendor	Peanuts	Russia.	U.S.A.

13. FATHER'S NAME Michael Rodgers

14 MOTHER'S MAIDEN NAME Agnes ——

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	——	——	Oliver Jordan	[redacted]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

DUE TO

(B) Arteriosclerotic heart disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 1 hr
(B) ?
(C)

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-28, 1949, *to* 2-12, 1949, *that I last saw the deceased alive on* ——, 19——, *and that death occurred at* —— m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
[signature] M. D.	Union Memorial Hosp	2-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/15/49	Baltimore	North Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington for Baltimore, Md.	Paul E. Shenouth Jr. 3615-17 Lakewood Ave.	

VS 150

937

Correct age is especially important. Physician, Hospital

✓ 594

G71539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71539

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Mary White [redacted]

2. DATE OF DEATH 2/11/49

3. PLACE OF DEATH
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1026 Bennett Place

c. Length of stay in Baltimore 35. Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1026 Bennett Place

5. SEX Female

6. COLOR OR RACE Col-

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH (Mo.) (Day) (Yr.) aug 19th 1896

9. AGE (In years last birthday) 54 5

If under 1 Year: Months / Days

If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10B. KIND OF BUSINESS OR INDUSTRY Working

11. BIRTHPLACE (State or foreign country) Heathsville Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Johnson

14. MOTHER'S MAIDEN NAME Alice Jones.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO.

17. INFORMANT Essie Jones ADDRESS 1026 Bennett Pl

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH 3 days.

DUE TO

(B) Hypertension

DUE TO

(C) Interstitial Nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 8th 1948 *to* Feb 11th 1949, *that I last saw the deceased alive on* Feb 11th 1949, *and that death occurred at* 1.30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE L. A. Gunn M. D.

23B. ADDRESS 522 Harlington

23C. DATE SIGNED 2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Feb 14-1949

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary

24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR FEB 14 1949

REGISTRAR'S SIGNATURE Thurlington Williams, M.D.

25. FUNERAL DIRECTOR V. Brooke

ADDRESS 1463 N. Carey St

VS 150

1310

V 42701

G71540

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71540

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret Bowers

2. DATE OF DEATH: Feb 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St 10 Yr

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	S	Sept. 13, 1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Sandy Fork Wash. Co.	

13. FATHER'S NAME: William Bowers

14. MOTHER'S MAIDEN NAME: Anna Lawn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Sister Ignatius ADDRESS 1200 Valley St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — Interval between onset and death: 5 yrs

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis — 10 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Chronic Bronchitis — 1 month

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb-1, 1949, *to* Feb 14, 1949, *that I last saw the deceased alive on* Feb 13, 1949, *and that death occurred at* 7-30A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. Gill Hall M.D. M. D.	1631 E. North ave	Feb 14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 17, 1949	St. Peters	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Rela Wedefeld

VS 150

93

BIRTH NO. 71541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71541

1. NAME OF DECEASED (Type or Print): Milton John Davids.

2. DATE OF DEATH: Feb. 12, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp.
c. Length of stay in Baltimore: Yrs. 27 Mos. Days 24

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5403 Hillburn Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 3-11-83
9. AGE (In years last birthday): 65 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Retired Attendant
10B. KIND OF BUSINESS OR INDUSTRY: American Oil Co.
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Henry C. Davids
14. MOTHER'S MAIDEN NAME: Elizabeth Kerner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Wm. Jenkins ADDRESS: 5403 Hillburn

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Obesity - Pulmonary Emphysema

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 8, 1949, to Feb 12, 1949, that I last saw the deceased alive on Feb 12, 1949, and that death occurred at 4 1/2 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Philip A. Reid M.D. M. D.
23B ADDRESS: 1400 N. Cowlin St.
23C. DATE SIGNED: Feb 16 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/16/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto Md
DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck
ADDRESS: 5305 Harford

VS 150

937

✓ 331

G71542 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71542 — Registered No.

1. NAME OF DECEASED (Type or Print): Annie A. Aumen

2. DATE OF DEATH: Feb. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1625 N. Hilton St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1625 N. Hilton St. 1607

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Feb. 9, 1868
9. AGE (In years last birthday): 81 yrs. — If under 1 year: Months, Days — If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife at home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Thomas McGee
14. MOTHER'S MAIDEN NAME: Annie Thomas McGee
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. E. B. VanDaniker — ADDRESS: 1625 N. Hilton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage — 2/12-49
DUE TO
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/15, 1949 *to* 2-/12, 1949 *that I last saw the deceased alive on* 2-/12, 1949 *and that death occurred at* 8.28 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Elias D. Bubert M. D.
23B. ADDRESS: 4803 Park Heights Ave.
23C. DATE SIGNED: 2-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-15-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Ceme.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Le Vernon Lemmon
ADDRESS: 4611 Pk. Hghts. Ave

VS 150

83a

Correct age is especially important

✓ 420.1

G71543 **BALTIMORE CITY HEALTH DEPARTMENT** G71543

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) JOHN ORESKI

2. DATE OF DEATH February 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1123 East Lombard Street 3-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Single	Unknown	50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailored		Russia	

13. FATHER'S NAME Nicholas Oreski

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	114-12-7809	John A Grebliauskas Jr

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Carl L Rose M.D

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED February 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/14/49	Holy Trinity Russian	Elkridge Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	John A Grebliauskas Jr	423 S. Paca St

VS 151

94a

Correct age is especially important. Physician: please

G71544 ✓ 411 G71544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): SAMUEL FORMAN
2. DATE OF DEATH: 2-13-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4042 Cold Spring Lane
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4042 Cold Spring Lane
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 37 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cab Driver
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Israel
14. MOTHER'S MAIDEN NAME: Anna
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): world war I
16. SOCIAL SECURITY NO.: 212-03-2310
INFORMANT: Gertrude Forman ADDRESS: 4042 Cold Spring Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) aortic stenosis & insufficiency
DUE TO rheumatic valvulitis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947 19 to 2/13/49 19, that I last saw the deceased alive on 2/13, 1949, and that death occurred at 8-1 m., from the causes and on the date stated above.

23A. SIGNATURE: Queen B Kents M D M. D.
23B. ADDRESS: 2320 Eutaw Pl
23C. DATE SIGNED: 2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-17-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Young Men
24D. LOCATION (City, town or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
24E. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Place

VS 150

92c

✓ 943 G71545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G71545 Registered No.

1. NAME OF DECEASED (Type or Print): BARNETT SAMUELS
2. DATE OF DEATH: 2-13-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. Gen. Hosp.
c. Length of stay in Baltimore: 40 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 21-01; D. STREET ADDRESS (If rural, give location): 3821 Beehler Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last Birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married		62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Benjamin
14. MOTHER'S MAIDEN NAME: Ida Mary
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 215-01-6109
17. INFORMANT: Dora Samuels ADDRESS: 3821 Beehler Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
(B) Essential hypertension — at least 18 mos.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypertensive arteriosclerotic cardio-vas dis.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
0	0	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
0	0	0

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
0 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/6 19 49 to 2/13 19 49 *that I last saw the deceased alive on* 2/13 19 49 *and that death occurred at* 1:15 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. Goldstein M. D.	WBGH	2/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-14-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Wilmington Williams M.D.	Jack Reavis Inc	2100 Eutaw Pl.

VS 150

Correct age is supplied by informant

931

G71546 331 G71546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SOLOMON BERLIN

2. DATE OF DEATH: 2-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1910 RUXTON AVE
c. Length of stay in Baltimore: 42 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D STREET ADDRESS (If rural, give location): 1910 RUXTON AVE

5. SEX	6 COLOR OR RACE	7 SINGLE, MARRIED WIDOWED DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
MALE	WHITE	MARRIED	APRIL 20 1876	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
RETIRED		RUSSIA	U.S.A.

13. FATHER'S NAME: ABRAHAM BERLIN

14 MOTHER'S MAIDEN NAME: FRUMA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16 SOCIAL SECURITY NO

17 INFORMANT: SARAH BERLIN - ADDRESS: 1910 RUXTON AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage - 12 days

DUE TO

(B) General arterio sclerosis?

DUE TO

(C) & Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb-2- 1949 *to* Feb. 13 - 1949 *that I last saw the deceased alive on* Feb-13- 1949 *and that death occurred at* 11 10 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Dr. Herman Seidel	2404 Eutaw Pl	2/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town or county) (State)
BURIAL	2-14-49	MT. CARMEL	BALTO. MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams M.D.	Jack Lewis Inc.	2100 Eutaw Place

VS 150

Correct age is important for ...

832a

G71547 ✓ 756.4 G71547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.-49-02678 Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH ANTHONY BADOLATO
2. DATE OF DEATH: Feb 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital, Balto. Md.
C. Length of stay in Baltimore: 7 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 411 E. Lake Ave Balto 12, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	single	Feb 5, 1949	—	—	7	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): New born
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S. ✓
13. FATHER'S NAME: Anthony Badolato
14. MOTHER'S MAIDEN NAME: Antoinette Cieri
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: Mercy Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Bronchopneumonia	4 days
DUE TO (B)	Interstitial Aspiration (Milk)	5 days
DUE TO (C)	Interstitial Obstruction	7 days
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Mongolian Idiacy Congenital Heart Disease Anemia	7 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 Feb 1949 to 12 Feb 1949, that I last saw the deceased alive on 12 Feb 1949, and that death occurred at 1 P. m., from the causes and on the date stated above.

23A. SIGNATURE: A. M. Bacon Jr. M. D.
23B. ADDRESS: Mercy Hospital Balto Md
23C. DATE SIGNED: 12 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	2-14-49	New Cathedral	Baltimore	Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: G. Howard Strong
ADDRESS: 3207 W. North Ave.

VS 150

157E

✓ 434.1

71548

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71548

Registered No.

1. NAME OF DECEASED (Type or Print): William Scott.

2. DATE OF DEATH: Feb. 10, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 213 N. Parrish St

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 213 N. Parrish St. 19 or

5. SEX: Male
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 5, 1885
9. AGE (In years last birthday): 63 | If Under 1 Year Months: Days | If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Howard Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm. Robert Scott.
14. MOTHER'S MAIDEN NAME: Jamé ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lola Scott. ADDRESS: 213 N. Parrish

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure
DUE TO Pulmonary Edema
Circulatory Collapse.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 7, 1949 *to* Feb 10, 1949, *that I last saw the deceased alive on* Feb 9, 1949 *and that death occurred at* 7:00 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: William Washington Jr. M. D.
23B. ADDRESS: 1535 W. Lafayette St.
23C. DATE SIGNED: Feb 14 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 14, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R Williams
ADDRESS: 322 N Schroeder St

VS 150

92E

G71549

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71549

1. NAME OF DECEASED (Type or Print): Henry J. Steinmuller

2. DATE OF DEATH: 2/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5001 Eugene Ave
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - Md
D. STREET ADDRESS (If rural, give location): 5001 Eugene Ave - 27-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M.	W.	Answer.	3 30 1809	79	10	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk.	Roofing Co	Baltimore Md	USA

13. FATHER'S NAME: Philip Steinmuller

14. MOTHER'S MAIDEN NAME: Margaret -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: 216-12-6297

17. INFORMANT: Mrs Wm J Steinmuller ADDRESS: 5001 Eugene Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Chronic Myocarditis	Nov. 12, 1948
DUE TO	(	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Generalized Arteriosclerosis	15 Years
DUE TO	(	
(C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Terminal Bronchial Pneumonia	5 Days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 12, 19 -, *to* Feb 12, 19 49, *that I last saw the deceased alive on* Feb 12, 19 49, *and that death occurred at* 2.55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Zacharias M. D.	4931 Park Ave	Feb 12 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/16/49	Mt Carmel	Baltimore Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	J. J. Zahn's Sons	1819 E. Lombard St

VS 150

Correct age is especially important

937

✓ 420.1

G71550

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71550

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLE JOSEPH SNYDER

2. DATE OF DEATH 2/12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland / 19 N Ostend St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 19 N Ostend St
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 19 N Ostend St 2-01

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

5. SEX M.

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower

8. DATE OF BIRTH 11 2 87

9. AGE (In years last birthday) 77 (If Under 1 Year: Months 3, Days 10; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Door Keeper

10B. KIND OF BUSINESS OR INDUSTRY Movies

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Snyder

14. MOTHER'S MAIDEN NAME Margaret

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.			INTERVAL BETWEEN ONSET AND DEATH
I	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Occlusion	2 hours
		DUE TO	—
	ANTECEDENT CAUSES	(B)	
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
		(C) Pleurisy (Right)	10 days
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-10 , 1949 *to* 2-12 , 1949 *that I last saw the deceased alive on* 2-11 1949 *and that death occurred at* 1:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE P. D. Ross M. D.

23B. ADDRESS 4 E. Chase St.

23C. DATE SIGNED 2-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 2/15/49

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town, or county) (State) Belair Rd Balto Md

25. FUNERAL DIRECTOR ADDRESS Foley & Sons, 220 Light St

DATE RECEIVED BY LOCAL REGISTRAR FEB 14 1949

REGISTRAR'S SIGNATURE Williams, M.D.

94a

VS 150

G71551 ✓141 X G71551

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ALEXANDER ANDREW MC DONALD

2. DATE OF DEATH: Feb. 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: 121 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Florida
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pensacola
D. STREET ADDRESS (If rural, give location): 232 E. Gregory St. ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	Aug. 7, 1880	68	6 / 5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Deckhand	Seafarer	Nova Scotia, Canada	Britian

13. FATHER'S NAME: Hector Mc Donald

14. MOTHER'S MAIDEN NAME: Margaret ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
Unknown	261-24-9944	Records- US Marine Hospital, Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Bronchopneumonia, lower lobes, bilateral	1-2 wks
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO	Carcinoma of tongue	2 yrs
(C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct. 14, 1948, *to* Feb. 12, 1949, *that I last saw the deceased alive on* Feb. 12, 1949 *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	US Marine Hospital, Balto, Md.	2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/17/49	Beach Branch Cem	Gloucester Mass

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	J. J. Daley & Sons	3. S Light St

VS 150

Correct age is especially important

456

✓ 442

G71552
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71552
Registered No.

1. NAME OF DECEASED (Type or Print): BENJAMIN MAYER.

2. DATE OF DEATH: 2/13/1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3243 Powhatan Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 54 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3243 Powhatan Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Married	Oct. 16, 1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Optometrist.	Germany.	U.S.A.

13. FATHER'S NAME: Jacob Mayer

14. MOTHER'S MAIDEN NAME: Philipine Fogle.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Mrs. Rosa Mayer,	3243 Powhatan Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteriosclerotic Cardiovascular Renal Disease	Dec 24, 1948
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 25, 1948 *to* Feb 13, 1949, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 3.30 A. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph S. Bloom M.D.	1115 N. Eutaw St.	2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/15/1949.	Baltimore Hebrew	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Harris Lowenheim & Son	1902 Eutaw Place.

VS 150

1319

Take to City Morgue
Keep appt approval

E 903.0
N-520.0

G71553

BIRTH NO. G71553

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71553

1. NAME OF DECEASED (Type or Print): Pauline Lowenberg
2. DATE OF DEATH: 2/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Rayner Ave r Dukeland St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
c. Length of stay in Baltimore: 80 Yrs. ___ Months ___ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2200 Eutaw Place #17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	W	Single	6/4/1860	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		New York	U.S.A

13. FATHER'S NAME: Adolph Lowenberg
14. MOTHER'S MAIDEN NAME: Caroline Burgunder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Mrs Rena Preston	5202 Fern Park Cire

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fractured Hip
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

CERTIFICATION APPROVED BY
C. A. Merrill M.D.
For: Wm. G. Helfrich M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
1/6/49	Open Reduction of fractured hip	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE. (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home	2200 Eutaw Place #17

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
1/4/49 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Fall - slipped & Fell to Floor

22. *I hereby certify that I attended the deceased from* 1/4, 1949, *to* 2/13, 1949, *that I last saw the deceased alive on* 2/13, 1949, *and that death occurred at* 3:50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Orlyn H. Wood M. D.	West Baltimore General Hosp.	2/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/15/1949	Hebrew Friendship	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	David Tomes Sim & Son	1902 Eutaw Place

VS 150

186a

71554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71554

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSHUA TURNER

2. DATE OF DEATH February 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 709 North Calhoun Street 16-02

5. SEX male

6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Dec 25, 1898

9. AGE (In years last birthday) 50

If Under 1 Year: Months / Days

If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) S. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Robert Turner

14. MOTHER'S MAIDEN NAME Lizzie Gifford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Robt. Turner — ADDRESS 1712 W Mulberry St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

20. AUTOPSY? YES ☐ NO ☒

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from* (Autopsy, Inspection or Inquiry) *the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Carl L Royer M.D

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR

23C. DATE SIGNED Feb. 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE Feb. 14/49

24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary

24D. LOCATION (City, town, or county) (State) Ellenton S. C.

DATE RECEIVED BY LOCAL REGISTRAR FEB 14 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Mrs Robt. A. Elliott & Daughter — ADDRESS 1129 N. Caroline St. 92D

VS 151

G71555 ✓ 42.7 G71555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Jerome J. O'Brien

2. DATE OF DEATH: 2/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1312 N. Fulton Avenue
c. Length of stay in Baltimore: 53 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1312 N. Fulton Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	Mar. 16, 1895	53	10 / 27	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
None	------	Baltimore, Maryland	

13. FATHER'S NAME: Michael C. O'Brien

14 MOTHER'S MAIDEN NAME: Mary Falvey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
		Mrs. Katharine Trussell	1312 N. Ful

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Chr. Encephalitis	19 yrs
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Chr. Myocarditis	1930
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 16, 1949 *to* Feb 13, 1949 *that I last saw the deceased alive on* Feb 12, 1949, *and that death occurred at* 8:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Jacob Braun M. D.	16340 - North Ave.	2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/16/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	H. W. Meade and Son	505 N. Calvert St.

VS 150

937

G71556 ✓ 4/22/1 G71556

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Joseph E. Classon

2. DATE OF DEATH: 2/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 217 W. Lorraine Avenue
C. Length of stay in Baltimore: 32 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 217 W. Lorraine Avenue 12-07

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 27, 1870
9. AGE (In years last birthday): 78 — If Under 1 Year: Months 7, Days 15 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired about 7Yrs
10B. KIND OF BUSINESS OR INDUSTRY: American Can Co.
11. BIRTHPLACE (State or foreign country): Taneytown, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Classon
14. MOTHER'S MAIDEN NAME: Lucy Cratin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mary L. Classon ADDRESS: 217 W. Lorraine

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) [illegible] — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1949 *to* Feb 12 1949, *that I last saw the deceased alive on* Feb 12, 1949, *and that death occurred at* 3:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. P. Sutcliffe M. D.
23B. ADDRESS: 1893 W Saratoga St
23C. DATE SIGNED: 2/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/15/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: FEB 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. C. Meares and Son ADDRESS: 703 N. Calvert St.

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G715:57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 715:57 Registered No. G715:57

1. NAME OF DECEASED (Type or Print) CLARENCE PATTERSON

2. DATE OF DEATH Feb. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1109 Argyle Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1109 Argyle Ave.

c. Length of stay in Baltimore 1 yr. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 1109 Argyle Ave.

5. SEX	6 COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
Male	Colored	Married	April 25, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Porter	B. & O. R. R.	Maryland	U. S. A.

13. FATHER'S NAME Not Known

14 MOTHER'S MAIDEN NAME Marcella ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
NO		705-03-903	Mrs. Catherine Patterson	1109 Argyle Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) arterio-sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: UNK.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B)
DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-13, 1949 *to* 2-12, 1949 *that I last saw the deceased alive on* 2/11, 1949 *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
[signature] M. D.	1500 E. Madison St	2-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2-15-49	Mt. Auburn Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Jesse W. Redden	436 W. Biddle St

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G71558 ✓ 153 G71558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Margaret Conner

2 DATE OF DEATH Feb. 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A STATE Md. B COUNTY Baltimore

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital

C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore: Nine yrs. (Yrs. Mos. Days)

D STREET ADDRESS (If rural, give location) 1413 W. Pratt Street

5. SEX	6. COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
female	White	Widowed	Nov. 17, 1893	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Kitchen helper	Hospital	Maryland	U. S.

13. FATHER'S NAME: Edward Stein

14 MOTHER'S MAIDEN NAME: Catherine Calderwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No	✓	Mrs. Dave E. Hewitt	68 S. Carrollton Ave Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of the colon & metastases	1 year ?
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
Jan. 13, 1949	Carcinoma of sigmoid colon and many metastases	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 11, 1949, *to* Feb. 14, 1949, *that I last saw the deceased alive on* Feb. 7, 1949, *and that death occurred at* 12 30 p m., *from the causes and on the date stated above.*

23A SIGNATURE	23B ADDRESS	23C DATE SIGNED
Walter B. Singer, M. D.	Bon Secours Hospital	Feb 7, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/07/49	St Lukes Cem	Cumberland Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	John J. Cowan & Son	9 Collins St.

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G7153 Bl 4 ✓447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G7153 9

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Ruth Hamlet

2. DATE OF DEATH: FEB 11 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1529 Clifton Ave 12 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Female	Colored	Married	1-16-11	37				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Va	

13. FATHER'S NAME: David Hastings

14. MOTHER'S MAIDEN NAME: Mary Vaughn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 215-12-9235

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriolar Nephrosclerosis with Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1½ mo

DUE TO

(B) Hypertensive Cardio Vascular Disease — 7 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-12 1949 *to* 2-11 1949 *that I last saw the deceased alive on* 2-11 1949 *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard S Ross M. D.	JOHNS HOPKINS HOSPITAL	12 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/15/1949	Arbutus Mem. Park.	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 14 1949	Huntington Williams, M.D.	George T. A. Gibson Sr. 1735 Druid Hill Ave.

131a

G71560 776 G71560

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO B.C. 49-1 3285 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Pollard
2. DATE OF DEATH: Feb 6, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp
c. Length of stay in Baltimore: 2 yrs (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D STREET ADDRESS (If rural, give location): 609 N. Brice St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months Days	If under 24 Hours: Hours Min.
Female	W		Feb 6, 1949			9

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John William Pollard
14. MOTHER'S MAIDEN NAME: Viola Imogene Sampson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mother ADDRESS: 609 N. Brice St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Immaturity - B.W. 1 lb 4 oz.	
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-6-49 19__, *to* 2-7-49, 19__, *that I last saw the deceased alive on* 2-7-49 19__, *and that death occurred at* 6:05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Pelton M. D.	West Balto. Gen'l Hosp	2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		University Medical School	FEB 10 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

159

✓ X 153

71561
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 71561

1. NAME OF DECEASED (Type or Print): Mr. Robert W. Fairbairn
2. DATE OF DEATH: 2-13-49
3. PLACE OF DEATH: A. Baltimore City, Maryland 33rd. & Calvert
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Virginia B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arlington
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp
c. Length of stay in Baltimore: ? Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 1934 N. Quinton Ave. [redacted]
5. SEX: M
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 6-18-1870
9. AGE (In years last birthday): 77 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Buffalo, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: George Pratt Fairbairn
14. MOTHER'S MAIDEN NAME: Christine Wetherston
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Carcinoma [redacted] of transverse colon	?
DUE TO (B)	Intestinal Obstruction	1-2 days
DUE TO (C)	Resection of terminal ileum, transverse & ascending colon	1 yr [redacted]

19A. DATE OF OPERATION: 2-13-49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of transverse colon & carcinomatosis
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-12, 1949, *to* 2-13, 1949, *that I last saw the deceased alive on* 2-13, 1949 *and that death occurred at* 7:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: John A. Sadler, M.D.
23B. ADDRESS: Union Memorial Hosp.
23C. DATE SIGNED: 2/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feby. 16 '49
24C. NAME OF CEMETERY OR CREMATORY: Forest Lawn
24D. LOCATION (City, town, or county) (State): Buffalo, N.Y.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: John D. Mitchell & Sons
ADDRESS: 1900 Eutaw Place

VS 150

46E

G71562 ✓ 442 G71562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): James M. Murphy
2. DATE OF DEATH: Feb. 10, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secour Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2106 Vine St
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov 11/10/01
9. AGE (In years last birthday): 47 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10B. KIND OF BUSINESS OR INDUSTRY: Own Hair Store
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James B. Murphy
14. MOTHER'S MAIDEN NAME: Anna Zeller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs Agnes Murphy ADDRESS: 2106 Vine St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Cardiovascular - renal Dis.
DUE TO
(C) nephrosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pulmonary oedema - Hypertension

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [✓] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 2, 1949 *to* Feb. 10, 1949 *that I last saw the deceased alive on* Feb. 10, 1949, *and that death occurred at* 6:30 P m. *from the causes and on the date stated above.*

23A. SIGNATURE: D. S. Mohler M. D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/14/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: FEB 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Frederick J. Ade
ADDRESS: 2300 W. Lombard

VS 150

131a

G71563 ✓ 204.1

BALTIMORE CITY HEALTH DEPARTMENT 420.1 G71563

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Albert J. Smith Sr

2. DATE OF DEATH Feb-12-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1803 E. Federal St

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1803 E. Federal St E 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	May-25-1875	73	8	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore - Md.	

13. FATHER'S NAME Mr. Smith

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
	216-03-2355	Catherine A. Smith

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — 5 yrs

DUE TO

(C) Myocardial Insufficiency — 2 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct, 1947, *to* Feb 12, 1949, *that I last saw the deceased alive on* Feb 10, 1949, *and that death occurred at* 2⁰⁰ p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Conrad L. Rusty M. D.	1201 N. Wash. St	2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-15-49	Woodlawn Cem	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Huntington Williams, M.D.	Robt C. Miller Inc	2435 E. Oliver

74a

71564

BALTIMORE CITY HEALTH DEPARTMENT 15 G71564

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Brown, Bradley

2. DATE OF DEATH 2-14-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland, B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Westminster (Rural)

D. STREET ADDRESS (If rural, give location) Reese

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	Oct 17, 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Md.	U.S.A.

13. FATHER'S NAME William Brown

14. MOTHER'S MAIDEN NAME Eliza Spencer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown	None	Vernon Brown	Owings Mills, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-vascular Renal

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of Pancreas & Extensive metastases

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2-14-49	Carcinoma of Pancreas	YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-11 *1949, to* 2-14 *, 1949 that I last saw the deceased alive on* 2-14 *, 1949, and that death occurred at* 1:55 P *m. from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph B. Lehnook M. D.	Franklin Sq. Hospital	2-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 17. 49	Sandymount	Westminster Md. R.D.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, MD	J. E. Myers, Jr.	Westminster Md.

VS 150

469

71565 ✓ 422.2 G71565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ARTHUR HENSKY

2. DATE OF DEATH February 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1501 Bolton Street

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1501 Bolton Street 1-4-61

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year Months Days	If under 24 hours Hours Min.
male	colored			64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Paul L Reyer		Feb. 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/15/49	Sacred Heart cem.	md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Deputy for Williams, M.D.	George E. Kelson	503 Pennsylvania Ave

VS 151

931

71566 ✓ 434.1

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71566

1. NAME OF DECEASED (Type or Print): BEATRICE BALL

2. DATE OF DEATH: February 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1411 Lafayette Avenue 16 0 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Single	12-8-1906	42 (DJM)		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Virginia	

13. FATHER'S NAME: Robert Nickens

14. MOTHER'S MAIDEN NAME: Minnie Montague

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	?	Mabel Monroe	1327 Presstman Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute congestive heart failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].

23A. SIGNATURE: Carl L. Boyer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 2-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-17-49	Kilmarnock, Va.	Va.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: George G. Kelson ADDRESS: 1303 Presstman St

93E

VS 151

~~71567~~ ✓ 420.1 G71567

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Menas "Mike Nick" Gaganichael
2. DATE OF DEATH FEB 13 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1641 E. Baltimore St 2 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	?/96	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook		Greece	

13. FATHER'S NAME Nicholas Gaganichael
14. MOTHER'S MAIDEN NAME Calliope Mastromenas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
	206-09-8329	JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardeal failure
DUE TO
(B) Coronary occlusion with
DUE TO
(C) myocardeal infarction

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 2-12- 1949 *to* 2-13- 1949, *that I last saw the deceased alive on* 2-13- 1949, *and that death occurred at* 2:35 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Callimahos M.D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/17/49	Greek Community ~~Greek Orthodox Church~~	Pikesville Md. ~~Pikesville Md.~~

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 15 1949	Huntington Williams, M.D.	Wm Cook Inc 1217 St. Paul St.

VS 150

94a

71568 1147 G71568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) **Mildred H Folger**

2. DATE OF DEATH Feb.14.1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1141 Ellicott Drive Ray

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1141 Ellicott Drive

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1141 Ellicott Drive 16 0 1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Married	Jan.14.1898	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore,Md.	

13. FATHER'S NAME Oscar E. Pace

14. MOTHER'S MAIDEN NAME Bertha A. Bush

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Mrs Mildred Cohan LO 5306	1141 Ellicott Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Carcinoma of Phyrnx, Primary	1 Month
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)		
	DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Jan 25, 49	Cancer of the wall of the phyrnx	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1, 1939, *to* Feb 13, 1949 *that I last saw the deceased alive on* Feb 13 1949, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph H. Mortimer Jr M.D.	2706 St Paul St	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/16/49	Moreland Park	Baltimore County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	William Lock, Inc.,	1217 St. Paul St.

VS 150

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671569

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

154 671569

Registered No.

1. NAME OF DECEASED (Type or Print): REBECCA PECOFSKY

2. DATE OF DEATH: 2-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai

c. Length of stay in Baltimore: 42 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution - residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3204 Durleith Ave 15-05

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 66 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Benjamin
14. MOTHER'S MAIDEN NAME: Rebecca
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Herman Ansell ADDRESS: 3204 Durleith Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARCINOMATOSIS
DUE TO
(B) CARCINOMA of RECTUM
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. THROMBOPHLEBITIS

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: JAN 20/1949
19B. MAJOR FINDINGS OF OPERATION: CARCINOMATOSIS
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-14 19 49 *to* 2-14 19 49, *that I last saw the deceased alive on* 2-14 19 49 *and that death occurred at* 6:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Katz M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 2-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-15-49
24C. NAME OF CEMETERY OR CREMATORY: United Hebrew
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 7 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

467

1570 ✓ 420.1 G71570

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Ida Elmyra Ensig

2. DATE OF DEATH Feb 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1606 N Castle St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) home

c. Length of stay in Baltimore Life 78 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 8-06
D. STREET ADDRESS (If rural, give location) 1606 N Castle St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Married	10-31-1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	home	Baltimore Md	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Henry Balto Md.	Harriette Brennan Balto Md

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	217-14-6298 D	Henry A Ensig (Husband)	1606 N Castle St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary occlusion	24 hrs
DUE TO		
(B)	Atherosclerosis	10 yrs
DUE TO		
(C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct, 1947 *to* Feb 14, 1949 *that I last saw the deceased alive on* Feb 13, 1949 *and that death occurred at* 9 00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Conrad L. Rutter M. D.	1706 N Wash. St.	2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-17-1949	Loudenslager Memorial Park	Taylor Ave 14 Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	Albert L. Weltz Jr	1606 N Chester St

VS 150

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✓443

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mrs Ruth Benoska

2. DATE OF DEATH: Feb 13, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 13
D. STREET ADDRESS (If rural, give location): 1715 N. Bethel St. E-06

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed.
8. DATE OF BIRTH: 12/22/97
9. AGE (In years last birthday): 52 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Eaton
14. MOTHER'S MAIDEN NAME: Alice ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mr. J. Donald Benoska- 5610 Ready Ave. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral thrombosis
DUE TO
(B) Hypertensive Cardio-Vascular Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 13, 1949, *to* Feb 13, 1949, *that I last saw the deceased alive on* Feb 13, 1949, *and that death occurred at* 11⁰⁵ *p.* m., *from the causes and on the date stated above.*

23A. SIGNATURE: Philip A. Pelo M.D. M. D.
23B. ADDRESS: 1400 N. Caroline St
23C. DATE SIGNED: Feb 25 49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 2/16/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC. BALTIMORE - 13, MARYLAND

VS 150

927

71572 ✓442 G71572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Charles Raymond Wagner
2. DATE OF DEATH Feb. 14, 49
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital
c. Length of stay in Baltimore Life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13
D. STREET ADDRESS (If rural, give location) 1724 Terrell place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Sept. 28, 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Night Watchman	Blackstone Apts.	Maryland	USA

13. FATHER'S NAME Charles H. Wagner
14. MOTHER'S MAIDEN NAME Emma Collier
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) WW1
16. SOCIAL SECURITY NO 218-07-7441
17. INFORMANT ADDRESS Mrs. Catherine Wagner- 1724 Terrell Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Uremia - chronic	5 days
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Hypertensive cardio - vascular renal disease	
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Arrhosis of Liver Bleeding gastric ulcer	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ✓ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 6 1949 *to* Feb. 14 1949, *that I last saw the deceased alive on* Feb. 13 1949, *and that death occurred at* 5-10 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Phillips A Price M.D. M. D.	1400 N. Carolina St	Feb. 14, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/16/49	Woodlawn Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 15 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC. BALTIMORE - 13, MARYLAND

VS 150

1241

71573 ✓ 171 G71573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Helen Boone

2 DATE OF DEATH Feb 13 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 723 S Bond St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A STATE 723 S. Bond St. B COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2 02

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore Life Yrs. Mon. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W.	Married	May 5 - 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Presser	Garment	Baltimore	

13. FATHER'S NAME Michael Szymanski

14. MOTHER'S MAIDEN NAME Rosalia Pruchnieska

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
	212-10-9779	Wm. Szymanski	723-S-Bond St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3-11 to 3-13

DUE TO

ANTECEDENT CAUSES

(B) Coronary Occlusion — Nov 1-1947

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO Metastasis

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov 1 1947 *to* Feb 13 1949, *that I last saw the deceased alive on* Feb 13, 1949, *and that death occurred at* 9 am. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William J. Ryan M. D.	801 Edgewood St	2-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb-16-1949	Holy Rosary	Gunman Hill Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	William S. Frelkowski	2007 Eastern Ave

VS 150

48a

71574 ✓ 420.1 G71574

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Frances Henrietta Curville

2. DATE OF DEATH: Feb. 12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp.

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3925 Flowerton Road 16-08

5. SEX: Female
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Dec. 28, 1873
9. AGE (In years last birthday): 75 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.: 1 / 14

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frederick G. Linck
14. MOTHER'S MAIDEN NAME: Mary Marie--------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS: Mrs S.W. Curville, 3925 Flowerton Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 months

DUE TO

(B) coronary artery disease — 4 months

DUE TO Hypertension

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-12, 1948 *to* 2-12, 1949, *that I last saw the deceased alive on* 2-12, 1949 *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: H W Scheyle M. D.
23B. ADDRESS: 3921 Edmondson ave.
23C. DATE SIGNED: 2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 15/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore, North Ave.
24D. LOCATION (City, town, or county) (State): & Gay St. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry N. Lutz
ADDRESS: 4101 Edmondson Ave.

VS 150

94a

71575 BALTIMORE CITY HEALTH DEPARTMENT E978.4 N862.2 71575

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): George Reid | 2. DATE OF DEATH: 2-11-49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. | B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1838 Presstman St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	C	Maried	June 14 1883 (189?)	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hotel Work	Hotel	Glass Nc	U.S.A.

13. FATHER'S NAME: Noah Reed
14. MOTHER'S MAIDEN NAME: Francis Moss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO

17. INFORMANT: Edith Reed | ADDRESS: 1838 Presstman St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., — heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed chest.
DUE TO Fractured jaw.
Fractured left femur.
(B) DUE TO Fractured right tibia
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Southern Hotel	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Light and Redwood Sts.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 2 11 49 approx 5:45P m.	21E. INJURY OCCURRED: WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR? Jumped from 12th story window

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED: 2-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/15/1949	Balto Nat. Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1949 | REGISTRAR'S SIGNATURE: Huntington for Williams, M.D. | 25. FUNERAL DIRECTOR: Elroy O. Wilson | ADDRESS: 1000 Brantly AVe.

VS 151

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G71576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71576 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph E Mills – Joseph E. Mills

2. DATE OF DEATH 2/14/49

3. PLACE OF DEATH
A. Baltimore City, Maryland 27 N Carey St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Hospital

C. Length of stay in Baltimore 25 Yrs. 4 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) Not Known 829 E Chase St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	W	Widowed	Jan. 7. 1883	66	1	7

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John F. Mills

14. MOTHER'S MAIDEN NAME Annie S. McLaughlin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Mrs Sadie V. Bily ADDRESS 3141 Churchfield Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: many

DUE TO

(B) Bronchitis Chronic

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/27/49 19__ *to* 2/14/49 19__, *that I last saw the deceased alive on* 2/14/49 19__, *and that death occurred at* 6-20 *m., from the causes and on the date stated above.*

23A. SIGNATURE Walter F Lemmon M. D.

23B. ADDRESS 40 E Chase St

23C. DATE SIGNED 2/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Feb 17/49

24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem

24D. LOCATION (City, town, or county) (State) 4300 Old Frederick Rd Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 15 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR Edmund W. Conklin ADDRESS 924 E. Eager St.

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715?7 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71577 Registered No.

1. NAME OF DECEASED (Type or Print): Maggie Carter

2. DATE OF DEATH: February 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 616 N. Carey St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 57 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 616 N. Carey Street 16-0 V

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Widowed	August 22, 1873	75	5	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Accomack, VA.
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: George Meade
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mary Williams ADDRESS: 616 N. Carey St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Day
DUE TO
(B) Cardio-Vascular Disease — Unknown
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-7, 1949, *to* 2-11-, 1949, *that I last saw the deceased alive on* 2-11-, 1949, *and that death occurred at* 1630 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard H. Hunt M. D.
23B. ADDRESS: 1631 W. Franklin St
23C. DATE SIGNED: 2-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: February 16, 1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Park
24D. LOCATION (City, town, or county) (State): Baltimore County Maryland

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph A. Sisly ADDRESS: 661 West Baltimore Street

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71578

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HATTIE BAILEY

2. DATE OF DEATH: 2/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 27 N. CAREY ST. Good Samaritan Home
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A STATE: MARYLAND
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D STREET ADDRESS (If rural, give location): 425 E. 23rd. St. 1204

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
FEMALE	COL	WIDOWED	1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
DOMESTIC		MARYLAND	

13. FATHER'S NAME: NED KARSEY

14. MOTHER'S MAIDEN NAME: EMLINE WILLIAMS.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: JOHN BAILEY ADDRESS: 425 E. 23rd. ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia, confluent — INTERVAL BETWEEN ONSET AND DEATH: months

DUE TO

(B) Arteriosclerosis

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/29/49 19__ *to* 2/13/49 19__, *that I last saw the deceased alive on* 2/14/49 19__, *and that death occurred at* 5:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C. DATE SIGNED
Wm. F. Norris, M.D.	401 Edmondson	2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
BURIAL	2/15/49	MT. ZION	LAKELAND, MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	LOTTIE GROSS	1408 Ashland ave

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 225 G71579

1. NAME OF DECEASED (Type or Print) SUMNER FRANCIS, SR.	2. DATE OF DEATH Feb. 13, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 201 St. Martin Rd. c. Length of stay in Baltimore Yrs. Mos. Days	4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Relay D. STREET ADDRESS (If rural, give location) 1601 Rolling Road
5. SEX male	6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 13, 1890
9. AGE (In years last birthday) 58 yrs.	If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper	10B. KIND OF BUSINESS OR INDUSTRY Consol.Eng. Co.
11. BIRTHPLACE (State or foreign country) Relay, Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Isaac H. Francie	14. MOTHER'S MAIDEN NAME Laura V.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ho (If yes, give war or dates of service)	16. SOCIAL SECURITY NO
17. INFORMANT Mrs. Sumner Francis	ADDRESS Relay, Md 1601 Rolling Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myeloma, multiple — INTERVAL BETWEEN ONSET AND DEATH: 4 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1949 *to* Feb 13, 1949 *that I last saw the deceased alive on* Feb 13, 1949 *and that death occurred at* 4 30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE William J Kelbech M. D.	23B ADDRESS 5006 Roland Ave	23C DATE SIGNED Feb 14, 1949
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/16/49	24C NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
DATE RECEIVED BY LOCAL REGISTRAR FEB 15 1949	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR ADDRESS WM. J. TICKNER & SONS Balto., Md.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): D. MEREDITH REESE
2. DATE OF DEATH: Feb. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 108 E. 32nd St.
c. Length of stay in Baltimore: 4 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 108 E. 32nd St. 12 0 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	June 4, 1873	75 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
salesman retired		Baltimore	

13. FATHER'S NAME: D. Meredith Reese
14. MOTHER'S MAIDEN NAME: Florence M. Daughtery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO		

17. INFORMANT: Mrs. Rosa L. Reese — ADDRESS: 108 E. 32nd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Occlusion	a few minutes
DUE TO (B)	Arterio Sclerosis	?
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Diabetes Mellitus	15 yrs +
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	none	none.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* about 1938 *to* 12 Feb 1949 *that I last saw the deceased alive on* 12 Feb 1949 *and that death occurred at* 6:50 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. Corbin Truett M. D.	712 Park Ave Balto Md	14 Feb 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/15/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams M.D.	WM. J. TICKNER & SONS	Balto., Md.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71581 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BELLEZETTA D. WOODEN

2. DATE OF DEATH: Feb. 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4700 Harford Rd. Harford Convalescent Home

c. Length of stay in Baltimore: 40 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2819 Roselawn Ave. 2206

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widow	March 18, 1870	78 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Coach Cleaner (rtd)	P. R. R.	Harford Co., Md.	

13. FATHER'S NAME: Holland Andrew

14 MOTHER'S MAIDEN NAME: Fannie Ritter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
-	-	Mrs. Elsie McCaffrey	2819 Roselawn Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Left Lung — Interval between onset and death: about 6Mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of Cervical Glands — unknown

DUE TO

(C) Myocardial Insufficiency — unknown

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 2nd. 1948, *to* Feb. 12th. 1949, *that I last saw the deceased alive on* Feb. 11th. 1949, *and that death occurred at* 11 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C DATE SIGNED
M. D.	401 E. 25th. St. Balto. 18, Md.	2/14/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/15/49	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Jas. W. Montgomery Jun. Registrar for Williams Mills	WM. J. TICKNER & SONS	Balto., Md.

VS 150

479

71582 ✓002 G71582

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): STANLEY RAKOWSKI

2. DATE OF DEATH: 2/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 844 S Kenwood ave

c. Length of stay in Baltimore: 58 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 844 S Kenwood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	1/89	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Poland	U S

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
✓	✓		Frances Rakowski	844 Kenwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis. — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) None
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
None	None	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 1941, 19, *to* Feb 13, 1949 *that I last saw the deceased alive on* Feb 12, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Gilchrunnuk M. D.	842 S. Ext Ave	2-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-16-49	St Stanislaus	Randall's I.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	John J. Kaczorowski	1313 Hanover St

VS 150

1583 ✓443 G71583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Markland H. Boyce Sr.

2. DATE OF DEATH: 2/13/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write INCORPORATED and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 514 N. Bouldin St. 26-10

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 514 N. Bouldin St.

c. Length of stay in Baltimore: 72 yrs. (Yrs. / Mos. / Days)

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan 9-1877
9. AGE (In years last birthday): 72 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.): 1 4
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: — Boyce
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Frances Boyce ADDRESS 514 N. Bouldin St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular Disease. — ?

DUE TO

(C) Chronic Cholecystitis — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify* that I attended the deceased from 2-12 1949 to 2-13 1949, that I last saw the *deceased alive on* 2-12 1949 and that death occurred at 8:30 P. M. from the causes and on the date stated above.

23A. SIGNATURE: Frances J. Janusezski M. D.
23B. ADDRESS: 546 N. Linwood Ave
23C. DATE SIGNED: 2/15/49

24A. BURIAL, CREMATION OR REMOVAL (Specify): Burial
24B. DATE: Feb 16/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cem
24D. LOCATION (City, town, or county): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Philip Herwig Sons
ADDRESS: 2024 Orleans St

VS 150

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1584

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): FRANKLIN H. ZOUCK
2. DATE OF DEATH: 2-14-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CATONSVILLE
D. STREET ADDRESS (If rural, give location): Box 211-B Wilkens Ave
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 8-28-75
9. AGE (In years last birthday): 73 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George
14. MOTHER'S MAIDEN NAME: Henrietta Ingham
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17 INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Myocardial Infarction Thrombus Right Ventricle — INTERVAL BETWEEN ONSET AND DEATH: 3 hours ?
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Bronchitis — 2 years

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/13, 1949 *to* 2/14, 1949 *that I last saw the deceased alive on* 2/14, 1949, *and that death occurred at* 6:25 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Stephen K. Padussis, M. D.
23B ADDRESS: St. Agnes Hospital
23C DATE SIGNED: 2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 17
24C NAME OF CEMETERY OR CREMATORY: St. Marys
24D LOCATION (City, town, or county) (State): Westminster Md. Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: Paul Chenoweth Jr.
ADDRESS: 3615-17 Chestnut Ave

VS 150

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G71585 BALTIMORE CITY HEALTH DEPARTMENT G71585

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) Bertha Caplan

2. DATE OF DEATH Feb. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1606 Gwynns Falls Parkway

c. Length of stay in Baltimore 25 yrs Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1606 Gwynns Falls Pkwy.

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow W | 8. DATE OF BIRTH Aug 17, 1885 | 9. AGE (In years last birthday) 63 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. | 4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Lazer Whitman

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS Mr Joseph L. Kewins 1606 Gwynns Falls Pkwy.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.
DUE TO Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension. —
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 1946 *to* Feb 15 1949 *that I last saw the deceased alive on* Feb 15 1949 *, and that death occurred at* 6 30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Kerbo, Kolman M D. | 23B. ADDRESS 3700 York Rd. Towson 4 | 23C. DATE SIGNED Feb 17 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/16/49 | 24C. NAME OF CEMETERY OR CREMATORY Bobroisker Hebrew Verein Randall | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 17 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS S. Levinson & Bros 1126 W. North Ave.

VS 150

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71586

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71586

Registered No.

BIRTH NO. B.C. 48-16194

1. NAME OF DECEASED (Type or Print): Baby Michael J. Swift

2. DATE OF DEATH: Feb. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY: Baltimore
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Rural — Pikesville
D STREET ADDRESS (If rural, give location): 21 Village Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	******	August 4, 1948		6 / 10	****

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
****	*****	Maryland	

13. FATHER'S NAME: James Raymond Swift

14. MOTHER'S MAIDEN NAME: Audra Merson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
**__	***	James R Swift 21 Village Rd Pikesville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pneumonia	
DUE TO (B)	otitis media	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Congenital malformations	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Feb. 13, 1949	otitis media	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 6 1949 *to* Feb. 14, 1949 *that I last saw the deceased alive on* Feb. 14, 1949, *and that death occurred at* 1:30 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. Shohler M. D.	Bon Secours Hosp.	2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 16 1949	St Charles Cemetery	Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
FEB 15 1949	Hunter Worthington Williams, M.D.	J Melville Jenkins 2713 Kirk Ave

VS 150

89a

G71587 /154 G71587

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ASBURY HENRY

2. DATE OF DEATH: 2/11/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2518 Druid Hill Av

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2518 Druid Hill Av. 12 03

c. Length of stay in Baltimore: 30yrs (Yrs. Mos. Days)

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 10/3/[illegible]
9. AGE (In years last birthday): 55 (If Under 1 Year: Months 4, Days 8; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Keeper
10B. KIND OF BUSINESS OR INDUSTRY: Groceries
11. BIRTHPLACE (State or foreign country): Talbot, County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Henry
14. MOTHER'S MAIDEN NAME: Alice Rideout

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: none
17. INFORMANT: Luvinia Henry (W) ADDRESS: 2518 Druid Hill Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of rectum — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1-16-48
19B. MAJOR FINDINGS OF OPERATION: Exposuda Ca Rectum
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-14 1949 *to* 2-11 1949, *that I last saw the deceased alive on* 2-11 1949, *and that death occurred at* 11:5 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Stanford P. Lumsden M. D.
23B. ADDRESS: 3309 Druid Hill Ave
23C. DATE SIGNED: 2-15-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/15/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): A.A.County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Charles G. Cooper — ADDRESS: 512 Carrollton Av.

VS 150

467

✓ 434.3

71588

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71588

Registered No.

1. NAME OF DECEASED (Type or Print): HANNA SHIPLEY

2. DATE OF DEATH: 2/10/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 525 W Lafayette Av

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 525 W. Lafayette Av 12-0 Y

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Widowed	1/14/1874	75	0	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unemployed		Va.	U.S.A.

13. FATHER'S NAME: James Lee

14. MOTHER'S MAIDEN NAME: Jane Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		None	Adelia Noel	525 W. Lafayette Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Organic Heart Disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: History indefinite

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 1 1948 *to* Feb 10 1949, *that I last saw the deceased alive on* Feb 10 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. Garland Ohnsell M. D.	1534 Druid Hill Ave	Feb 14 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/16/49	Mt. Calvary	A.A.County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	Charles G. Cooper	512 Carrollton Av.

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✓ H22.1 G71589

71589

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71589

1. NAME OF DECEASED (Type or Print): Emma J. Billau

2. DATE OF DEATH: Feb 14 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2514 Talbot Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2514 Talbot Road

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Sept 24 1852
9. AGE (In years last birthday): 96 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Watertown N.Y.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harlow Scoville

14. MOTHER'S MAIDEN NAME: Alzina ---------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Lewis S. Billau 2514 Talbot Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocarditis 1
DUE TO
(B) Arteriosclerosis 1°
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) about 2 weeks; (B) 1°

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 2 49, 19, *to* Feb 14, 1949, *that I last saw the deceased alive on* Feb 13, 1949, *and that death occurred at* 8:20 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter D. Tulloch M. D.
23B. ADDRESS: 220 Harrison Blvd
23C. DATE SIGNED: Feb. 14 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: Feb 17 1949
24C. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
24D. LOCATION (City, town, or county) (State): Washington Road Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Henry H. Armacost
ADDRESS: 4204 Ridgewood Ave

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G71590

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71590

BIRTH NO.

1. NAME OF DECEASED (Type or Print): also known as DANIEL ALEXANDER DUNSON — DATE OF DEATH: Feb. 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md. B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 1529 W. Fairmont Ave. 19 c r

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	col	Widower	? 1885	64	?	?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Union level, Va.	USA

13. FATHER'S NAME: H ardy Dunson

14. MOTHER'S MAIDEN NAME: Mary Alice Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW I	?	Records- US Marine Hospital, Balto, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage suspected — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs

DUE TO

(B) arteriosclerosis, general

DUE TO

(C) Arteriosclerotic heart disease — Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 10, 1949, *to* Feb. 12, 1949, *that I last saw the deceased alive on* Feb. 12, 1949, *and that death occurred at* 7:50A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	US Marine Hospital, Balto, Md.	2/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/16/49	W. Lawn Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	Mrs Kate R. Williams & Schroeder Lt.	822 N

VS 150

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G71591 BIRTH NO.

✓ 443

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71591

1. NAME OF DECEASED (Type or Print): Elizabeth A. Dominick

2. DATE OF DEATH: Feb 13th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1727 N. Bradford St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1727 N. Bradford St

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Feb 28th 1875
9. AGE (In years last birthday): 73 (Under 1 Year: Months / Days; Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Mag Noe
14. MOTHER'S MAIDEN NAME: Mary Ebel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Marie Dominick ADDRESS: 1727 Bradford St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteriosclerotic Cardio-Vascular disease	3 yrs
DUE TO (B)	Hypertension, unknown	unknown
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Nov 1946 *to* Feb 13 1949, *that I last saw the deceased alive on* Feb 13 1949, *and that death occurred at* 6.40 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Howard Hillman M. D.
23B. ADDRESS: 1513 N. Milton Ave
23C. DATE SIGNED: 14 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: Feb 17th 1949
24C. NAME OF CEMETERY OR CREMATORY: Baltoleum
24D. LOCATION (City, town, or county) (State): E North Ave Ext

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1948
REGISTRAR'S SIGNATURE: Hunting for Williams M.D.
25. FUNERAL DIRECTOR: Lee & Leach ADDRESS: 1701-03 N. Patterson Park ave

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MacSherry ✓151 X

G71592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71592

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Richard Macsherry

2. DATE OF DEATH Feb. 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Hosp. Mbg 3

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY Talbot
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orchard Core
D. STREET ADDRESS (If rural, give location) Easton

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	8-26-86	62 yrs	5	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer		Md	

13. FATHER'S NAME Richard MacSherry

14. MOTHER'S MAIDEN NAME Emily Hillen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH ± 6 mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Malnutrition due to Esophageal Obstruction

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION February 9, 1949 — 19B. MAJOR FINDINGS OF OPERATION Inoperable Carcinoma — 20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-4-, 1949 *to* 2-14-, 1949 *that I last saw the deceased alive on* 2/14, 1949 *and that death occurred at* 4:15 p m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D. — 23B. ADDRESS JOHNS HOPKINS HOSPITAL — 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/16/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	H. C. Meads and Son	805 N. Calvert St.

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G71593

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71593 Registered No. 3698

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALBERT HOLMES

2 DATE OF DEATH 2-13-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1202 Harlem ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 35 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D STREET ADDRESS (If rural, give location) 1202 Harlem ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	colored	married	Feb 1888	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Richmond Co Va
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME Unknown
14 MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown
16. SOCIAL SECURITY NO.
17. INFORMANT Reditha Holmes (Wife) ADDRESS 1202 Harlem

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH over 4 years
DUE TO
(B) Renal Calculi. — over 12 years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-4-, 1944 *to* 2-13-, 1949, *that I last saw the deceased alive on* 2-12-1949 *and that death occurred at* 8:20 A.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank A Saunders M. D.	1029 N. Stricker St.	2-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 16-1949	Lotteburg Church Cemetery Va	Lottsburg Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	Va Brooks	1465 N. Carey

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G71594 ✓443 G71594

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): **Frank R.Sanders**

2. DATE OF DEATH: **2-13-49**

3. PLACE OF DEATH: A. Baltimore City, Maryland **1512 E Lanvale Street**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY **Balto:City**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

c. Length of stay in Baltimore **Life** Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) **1512 E.Lanvale Street** 8 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Divorced	9-19-1876	72	4 / 25	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Wireworks	Maryland	U.S.A.

13. FATHER'S NAME: **James A.Sanders**

14. MOTHER'S MAIDEN NAME: **Julia F.Hammer**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	?	Seamon Nennstiel ,1713 Cliftvied Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: One year

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 1949 *to* Feb. 13, 1949 *that I last saw the deceased alive on* Feb 12, 1949, *and that death occurred at* 5:00 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. H. Frenzel M.D.	1702 E Lanvale St.	2.14.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-16-49	Parkwood Cemetery	Taylor Avenue, Balto:County

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 15 1949	Huntington Williams, M.D.	George J.Ruth,Inc. 1735 Harford Avenue

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G71595

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71595

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alexander BUTLER

2. DATE OF DEATH: 2/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): No. 4 Spring Street
c. Length of stay in Baltimore: 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): No. 4 Spring Street, N. 501

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	Negro	Widower	March 3 1877	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman		Calvert County	USA

13. FATHER'S NAME: Daniel BUTLER

14. MOTHER'S MAIDEN NAME: Martha Bargus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	213-128-670	Henry Campbell	1205 West Lanvale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac dilatation

DUE TO

(B) Chronic Myocardial failure

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/11 19[4]0, *to* 2/14, 19[4]9, *that I last saw the deceased alive on* 2/14, 1949, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr S. C Feldman M. D.	1490 E Baltimore	2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 16th.49	Brooks Chapel	Calvert County, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 17 1949	Huntington Williams, M.D.	Charles H. Alexander	1200 McCulloh St.

VS 150

93E

G71596

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71596

Registered No.

1. NAME OF DECEASED (Type or Print): ARTHUR DIGGS

2. DATE OF DEATH: Feb. 14 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: CALVERT
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parran P.O.
D. STREET ADDRESS (If rural, give location)

5. SEX: male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 3-20-28
9. AGE (In years last birthday): 20 | If under 1 year: Months / Days | If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farm hand
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wash. D. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Warren Garman
14. MOTHER'S MAIDEN NAME: Essie Diggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Subarachnoid Hemorrhage due to aneurysm of Circle of Willis	36 hrs
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Mediastinal Emphysema	36 hrs

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/13 1949 *to* 2/14 1949 *that I last saw the deceased alive on* 2/14 1949 *and that death occurred at* 3:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Richard S Ross M. D.
23B ADDRESS: JOHNS HOPKINS HOSPITAL
23C DATE SIGNED: 2.15.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/16/49
24C. NAME OF CEMETERY OR CREMATORY: Plum Point Cem.
24D LOCATION (City, town, or county) (State): Calvert Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas. H. Alexander
ADDRESS: 1200 McCulloh St.

VS 150

82a

G71597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1

Registered No. G71597

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MAGGIE LEHNER

2. DATE OF DEATH: February 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2651 Lehman Street

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2651 Lehman Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	Nov 7 1875	73	3			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Somestic		Germany	

13. FATHER'S NAME: —

14 MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Fredk W Lahm	2657 Lehman St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George L. Merrill M.D		2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Feb 17/49	Cathedral	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	Uhl Funeral Home	2008 Orleans

VS 151

94a

CERTIFICATE CORRECTED 3-N-49 443 ✓

G71598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71598

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CONSTANTIN MILLER

2. DATE OF DEATH 2/13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL

c. Length of stay in Baltimore 22 (22) YEARS Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 3213 DUNCAN PLACE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W		OCT 28 1893	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
UPHOLSTERER		GERMANY	(S) USA

13. FATHER'S NAME MILLER

14. MOTHER'S MAIDEN NAME ANNA RAUFENBARTH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HEMORRHAGE - LEFT MIDDLE MENINGEAL ARTERY

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) HYPERTENSIVE CVD

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/13, 1949 *to* 2/13, 1949 *that I last saw the deceased alive on* 2/13, 1949 *and that death occurred at* 2.05 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald W. Mintz M. D.	Church Home + Hosp.	2/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 16 49	Moreland Park	Balto Co

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	Uhlmeyer Funeral Home	2008 Orleans

VS 150

937

G71599 ✓ 153 G71599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): John Fields
2. DATE OF DEATH: Feb 13/49
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE 2212 Eastern Ave B. COUNTY
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
c. Length of stay in Baltimore: Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 2212 Eastern Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	widower	May 12-82	66	8	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Balto City	Balto	

13. FATHER'S NAME: James W Fields
14. MOTHER'S MAIDEN NAME: Elizabeth Lehman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Melvin Fields ADDRESS: 2212 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Bronchio pneumonia	20 hrs.
DUE TO (B)	Nephritis - Cystitis	2 months
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Carcinoma of Cecum	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
December 1948	Carcinoma of Cecum.	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Jan 11 1949 to Feb 13, 1949, *that I last saw the deceased alive on* Feb 12, 1949, *and that death occurred at* 9.25 *m. from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James L. Insley M. D.	2936 E. Baltimore St	2/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 16/49	Greenmount Cem	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	Uhland Funeral Home	1708 Orleans

VS 150

46 E

G71600

BIRTH NO. BCH-81193

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E812.4 N803.0 G71600

Registered No.

1. NAME OF DECEASED (Type or Print): LORAINE ROGERS

2. DATE OF DEATH: February 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 2121 Hawkins Point Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White		June 16 - 1947	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: A. Rogers
14. MOTHER'S MAIDEN NAME: Ruth Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: A. Rogers — ADDRESS: 2121 Hawkins

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fractured skull
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Pennington Avenue & Curtis Creek Bridge
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): February 14, 1949 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Pedestrian struck by auto 2515

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L. Voigt M.D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 2-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: Feb 17 - 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross Cem
24D. LOCATION (City, town, or county) (State): Anundel County

DATE RECEIVED BY LOCAL REGISTRAR: FEB 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: B. Hale — ADDRESS: 121 E. West St

VS 151

170C

✓ 591.0 X

G71601 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71601 — Registered No.

1. NAME OF DECEASED (Type or Print): ELLIS SCOTT PARLETT

2. DATE OF DEATH: Feb. 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: 70 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Severena Park
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	2/13/96	53	- / 2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plasterer	?	Pa.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harry Parlett	Margaret Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	WW I	?	Records-	US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Portal cirrhosis	Unknown
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Dec. 7, 1948, *to* Feb. 15, 1949, *that I last saw the deceased alive on* Feb. 15, 1949, *and that death occurred at* 12:25 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M.D.	US Marine Hospital, Balto, Md.	2/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	2-17-49	ARLINGTON, VA.	ARLINGTON-VA.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, MD	[illegible]	[illegible]

VS 150

1248

G71602 776 G71602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-04795 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Bertel

2. DATE OF DEATH: 2-14-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: 3-4 HRS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3212 Stanley Rd. Balto 17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W		2/14/49			4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	

13. FATHER'S NAME: Lawrance Bertel

14. MOTHER'S MAIDEN NAME: Elizabeth Bertel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Lawrence Bertel ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity — (INTERVAL BETWEEN ONSET AND DEATH) 4 Hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/14, 1949 *to* 2/14, 1949, *that I last saw the deceased alive on* 2/14, 1949, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert E. Ewer M.D.	Mercy Hospital	2/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-17-49	Catholic	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington Williams, M.D.	Sindfield & Son	Gremont 2-2-2

VS 150

1-59

71603 BALTIMORE CITY HEALTH DEPARTMENT G71603

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret - A. Hesterberg

2. DATE OF DEATH 2/10/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 921 DeSoto Road

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 921 DeSoto Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Month	If under 1 Day	If under 24 Hours
Female	White	Married	6/28/1872	76			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife.	Dr. Home	Baltimore-Md.	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frederick Schantz	Hess Nee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Wm. H. D. Hesterberg	921 DeSoto Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(B) Chronic Nephritis & Myocarditis — 2 yrs. / 10 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 47 *to* Feb 10, 1949 *that I last saw the deceased alive on* Feb 9, 1949 *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas Bowyer M. D.	221 Med Arts Bldg	2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/14/1949	Loudon Park Cem.	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 15 1949	Huntington for Williams, M.D.	F. D. Wippert & Son	800 Eutaw Pl.

VS 150

1310

17

71604 ✓181 G71604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or print) EMMA SHARON LEVANDER

2. DATE OF DEATH Feb. 15 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 303 Oakdale Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white		10-10-05	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Consultant		Wisconsin	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edwin Johnson	Lena Hansen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSP.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis of Abdomen — INTERVAL BETWEEN ONSET AND DEATH: 4 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma Urinary Bladder — 1½ years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/13 1949 *to* 2/15 1949, *that I last saw the deceased alive on* 2/15 1949, *and that death occurred at* 10:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Crawford B Shier M. D.	JOHNS HOPKINS HOSP.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
cremation	2/17/49	Green Mount	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 7 1949	Huntington Williams M.D.	Wilson Colton 1211 N. Eutaw St

VS 150

526

71605 442 G71605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ida A. Poplar

2. DATE OF DEATH: Feb 13th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 724 Bartlett Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 724 Bartlett Ave 908

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed	5/28/1874	74	8 15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Fremont Ohio	U. S. A.

13. FATHER'S NAME: George De Mars

14. MOTHER'S MAIDEN NAME: Cordelia Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Elizabeth Heiny	724 Bartlett Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cardio Vascular Renal Disease	yrs
DUE TO (B)	Arteriosclerosis	2 yrs
DUE TO (C)	Hypostatic Pneumonia	1 yr.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept. 1948 *to* Feb 13, 1949 *that I last saw the deceased alive on* Feb 13, 1949, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hunter Smith M. D.	3809 Fremont Ave	2/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/16/49	Angel Hill	Havre de Grace Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 16 1949	Huntington Williams M.D.	Wm Cook Inc.	1217 St. Paul St

VS 150

131a

71606 BARNHART 422.1 G71606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Erma Barnhart

2. DATE OF DEATH 2/14/49

3. PLACE OF DEATH
A. Baltimore City, Maryland 24 N Carey St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
B. CITY Md. City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-04
D. STREET ADDRESS (If rural, give location) 607 Penna. Ave

5. SEX F
6. COLOR OR RACE B
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH
9. AGE (In years last birthday) 77 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Myocarditis — months
DUE TO
(B) Arteriosclerosis
DUE TO
(C) Senility

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/31/48 19__ *to* 2/14/49 19__ *that I last saw the deceased alive on* 2/13/49 19__ *and that death occurred at* 6:24 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Walter F Loveren M.D.
23B. ADDRESS 607 Edmondson
23C. DATE SIGNED 2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 2/17/49
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvery
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 16 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR A. Halstead
ADDRESS 918-931 Druid Hill Ave.

VS 150

521 ✓

G71607 | BALTIMORE CITY HEALTH DEPARTMENT | G71607

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen A. A. Smith

2 DATE OF DEATH: February 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 5701 Roland Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

C. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY: Baltimore City
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 5701 Roland Ave. 2 7 3

5. SEX	6. COLOR or RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
female	white	single	July 17, 1888	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
none		Baltimore, Md.	U.S.A.

13. FATHER'S NAME: J. Hume Smith

14 MOTHER'S MAIDEN NAME: Annie A. Milligan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT: Mrs. Leslie D. Foster ADDRESS: 5701 Roland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pulmonary Hemorrhage	2 days
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Chronic pulmonary abscess	40 yrs.
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/2/49, 19__, *to* 2/13/49, 19__, *that I last saw the deceased alive on* 2/13/49, 19__, *and that death occurred at* 10:37 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Francis W. Gluck M. D.	3406 St. Paul St.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/16/49	Lorraine	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 16 1949	Huntington Williams, M.D.	John O. Mitchell & Sons	1900 Eutaw Pl.

VS 150

1147

71608 ✓422.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 71608

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM B. DIGGS

2. DATE OF DEATH: February 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 3020 Auchentoroly Terrace 13-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		June 1. 1864	84	8 / 14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	R.R. Pass Ch.	Balto	U.S. ✓

13. FATHER'S NAME: Wm. B. Diggs
14. MOTHER'S MAIDEN NAME: Anne McDermott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: A. Helen Diggs ADDRESS: 3020 Auchentoroly Ter.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocardial hypertrophy
arteriosclerosis

(C) Ununited fracture of left femur.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Office Bldg.
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Fidelity Trust Building

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): December 20, 1948 m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Caught in revolving door

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR
23C. DATE SIGNED: 2-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feby 17/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount
24D. LOCATION (City, town, or county) (State): Greenmount & North Aves

DATE RECEIVED BY LOCAL REGISTRAR: FEB 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Mitchell Sons ADDRESS: 1900 Eutaw Place

VS 151

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71609
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71609

1. NAME OF DECEASED (Type or Print): Caroline A. Harman

2. DATE OF DEATH: February 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 201 Ridgewood Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

c. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 201 Ridgewood Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	July 30, 1855	93		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Centerville, Md.	U.S.A.

13. FATHER'S NAME: Samuel H. Richardson

14. MOTHER'S MAIDEN NAME: Susan Straughn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Clarence Eaton	201 Ridgewood Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) General arterio-sclerosis	10 years
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Cardiac decompensation	1 day

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
— m.	—	—

22. *I hereby certify that I attended the deceased from* Feb. 1, 1949 *to* Feb. 14, 1949 *that I last saw the deceased alive on* Feb 14, 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Stephen F. Stellmann M. D.	6 E. Biddle St.	2/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	2/16/49	Druid Ridge	Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 16 1949	Huntington Williams, M.D.	John O. Mitchell & Sons Co. per MM Mitchell	1900 Eutaw Pl.

VS 150

71610 ✓331 G71610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRIET ANN GREASLEY

2. DATE OF DEATH: Feb. 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 105 Tunbridge Rd. 2-17

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 105 Tunbridge Rd.

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
female	white	widow	Sept. 23, 1867	81 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Wilson Kerr
14. MOTHER'S MAIDEN NAME: Mary Gardner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: no
17. INFORMANT: Mrs. Wm. A. Seiler ADDRESS: 105 Tunbridge Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — (Interval between onset and death): 6 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio sclerosis — 15 years.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 11, 1949 *to* Feb. 14, 1949, *that I last saw the deceased alive on* Feb 14 1949, *and that death occurred at* 11 3/4 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Anthony J Davis M. D.
23B. ADDRESS: 2004 E 33rd St
23C. DATE SIGNED: 2-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/16/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

839

71611 ✓422.1 G71611

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JENNIE LEE SAPP

2. DATE OF DEATH: Feb. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for the Aged of the Methodist Church
2211 W. Rogers Avenue

c. Length of stay in Baltimore: Yrs. 2 Mos. 7 Days 15

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 N. Rogers Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Feb. 5, 1866
9. AGE (In years last birthday): 83 yrs.
If under 1 year: Months / Days
If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Halstrum
14. MOTHER'S MAIDEN NAME: Elizabeth Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Miss M. B. Fisher
ADDRESS: 2211 N. Rogers Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myocardial Insufficiency	5 days
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Arteriosclerosis	years.
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 20, 1948 *to* Feb 14, 1949 *that I last saw the deceased alive on* Feb 13, 1949, *and that death occurred at* 3.15 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Arthur J Bonney M. D.
23B. ADDRESS: 200 W 34th St
23C. DATE SIGNED: 2-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/16/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

93D

71612 ✓151 G71612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Walford

2. DATE OF DEATH: 2/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: 51 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore,
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Md.
D. STREET ADDRESS (If rural, give location): 1303 Brunt St. 17 ward

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	C	Married	Dec. 27, 1895	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Married	Hanover Co, Va "	U.S.A.

13. FATHER'S NAME: Robert Wolford

14. MOTHER'S MAIDEN NAME: Louise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO: 219-10-4313

17. INFORMANT: Dorothy Wolford. ADDRESS: 1303 Brunt St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	2/16/49	Mt Auburn Cem	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 16 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Mrs Katie R Williams ADDRESS: 3224 Edmondson

VS 151

46B

✓ 443

71613 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71613

1. NAME OF DECEASED (Type or Print): Joseph Cornelious Nicholson

2. DATE OF DEATH: February 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1339 W. 42nd Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1339 W. 42nd Street /3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Widower	March 15, 1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Car Inspector Retired	Pa. Railroad	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Nicholson	Margaret Keys

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	717-07-7343 A	Mrs. Lillian G. Mitchell	1339 W. 42nd St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrage — INTERVAL BETWEEN ONSET AND DEATH: 3da.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Hypertensive C V D. — ?

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1944 *to* Feb 14, 1949 *that I last saw the deceased alive on* Feb 14, 1949, *and that death occurred at* 11A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lawrence Schumann M.D.	3716 Fallsrd	Feb 17 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 17, 1949	Wesley Chapel	Carroll Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 16 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

937

5/4200

G71614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71614

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JULIA W. HECHT.

2. DATE OF DEATH 2/14/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Green Spring Manor Apts.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park Heights Ave

c. Length of stay in Baltimore 80 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) Green Spring Manor Apts.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Female	White	Widow

8. DATE OF BIRTH 2/11/1869.
9. AGE (In years last birthday) 80 (If Under 1 Year: Months, Days) (If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Isreal Whitehill

14. MOTHER'S MAIDEN NAME Rachel Mandelbaum.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Mr. F. Kaufman, ADDRESS First Nat'l Bank Bldg.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

A) Coronary occlusion & myocard. infarction. — INTERVAL BETWEEN ONSET AND DEATH: 2 hours.

DUE TO

B) Arterio-sclerosis — 2 yrs.

DUE TO

C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 1, 1948 *to* Feb. 14, 1949 *that I last saw the deceased alive on* Feb. 14, 1949 *and that death occurred at* 12 10 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE Nathan B. Herman M.D.
23B. ADDRESS
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 2/16/1949.
24C. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew
24D. LOCATION (City, town or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 16 1949
REGISTRAR'S SIGNATURE Interim for Williams, M.D.
25. FUNERAL DIRECTOR AND ADDRESS Harold Levine & Son 1902 Eutaw Place.

VS 150

94a

✓ 450.0

71615

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71615

Registered No.

1. NAME OF DECEASED (Type or Print): ANDREW N. DANNEMAN

2. DATE OF DEATH: 2/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 727 S. CURLEY ST.
c. Length of stay in Baltimore: LIFE (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 727 S. CURLEY ST. 1-01

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 5/14/1873
9. AGE (In years last birthday): 75 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MANUFACTUER
10B. KIND OF BUSINESS OR INDUSTRY: CIGARS
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: GEO. DANNAMEN
14. MOTHER'S MAIDEN NAME: BARBARA ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ANNA DANNEMAN
ADDRESS: 727 S. CURLEY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 days.
DUE TO
(B) Senile Arteriosclerosis — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 10, 1949, to Feb. 14, 1949, that I last saw the deceased alive on Feb. 14, 1949, and that death occurred at 1:15 P. m., from the causes and on the date stated above.

23A. SIGNATURE: Clarence W. LeGoup M. D.
23B. ADDRESS: 3023 Eastern Ave.
23C. DATE SIGNED: 2/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
24B. DATE: 2/17/49
24C. NAME OF CEMETERY OR CREMATORY: GREENMOUNT
24D. LOCATION (City, town, or county) (State): BALTO. CITY

DATE RECEIVED BY LOCAL REGISTRAR: FEB 16 1949
REGISTRAR'S SIGNATURE: Beatrice Williams, M
25. FUNERAL DIRECTOR: Lilly & Zeiler Inc.
ADDRESS: 403 S. WOLFE

VS 150

937

71616 ✓ 420.1 G71616

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) ALBERT ROBINSON

2. DATE OF DEATH February 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 914 S. Curley Street
c. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 914 South Curley Street 1-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
male	white	MARRIED	7/25/1901	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INSPECTOR	AUTO MFG.	MD.	U.S.A.

13. FATHER'S NAME WALTER ROBINSON

14. MOTHER'S MAIDEN NAME MAMIE ROSE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			CAROLINE ROBINSON	914 S. CURLEY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L. Kruger M.D | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED Feb. 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
2/18/49	BURIAL	BALTO. CEM.	BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 16 1949	Printing for Williams, MD	Lilly & Zeiler Inc.	942

VS 151

71617 177 X 671617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr Paul A. Horning

2. DATE OF DEATH: 14 Feb. 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp
c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission):
A STATE Md.
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville
D STREET ADDRESS (If rural, give location): 5160 New Edmondson Blvd.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 3/28/75
9. AGE (In years last birthday): 73 — If Under 1 Year: Months 10, Days 16 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Paul A. Horning
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Miss Anne Stegman — ADDRESS: 5160 New Edm. Blvd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of prostate
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 24 1949 *to* Feb. 14, 1949 *that I last saw the deceased alive on* Feb. 14, 1949 *and that death occurred at* 10 1/4 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Robert Liberto M.D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 14 Feb. 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 17/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town or county) (State): 4300 Old Frdk. Rd. Balto 2 Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 16 1949
REGISTRAR'S SIGNATURE: Thurston Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Lutz
ADDRESS: E-410 Edmondson Ave

VS 150

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71618 ✓ 422.1 71618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John L Lee

2. DATE OF DEATH Feb. 14'49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 404 Hazlett Ave

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 404 Hazlett Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
Male	White	Married	June 5, 1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Const. Engineer	U.S. Gov't	Maine	

13. FATHER'S NAME Lee

14 MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
Yes	W.W. I		Mrs John L Lee	404 Hazlett Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Chr. Congestive Myocarditis	Indefinite
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	arteriosclerosis - Chr. glomerular nephritis	over 7 yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb, 1949 *to* Feb 14, 1949 *that I last saw the deceased alive on* Feb 10, 1949 *and that death occurred at* 10A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathaniel M Beck M.D.	1009 23rd Bromfield	Feb 16 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Feb. 17, 49	Holy Redeemer	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 16 1949	Huntington Williams, M.D.	Harry L Wetzler	440 Edmondson Ave

VS 150

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71619 ✓ D&S E-71619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Champhor

2. DATE OF DEATH 2/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 417 N. Chapel St.

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-04
D. STREET ADDRESS (If rural, give location) 417 N. Chapel St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F	C	Widowed	July 4, 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Eliza Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Viola Johnson	417 N. Chapel St.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive Cardiovascular Disease

DUE TO

(C) Arteriosclerosis, Generalized

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Dr. Robert McFadden, Jrs. per M.D.	☐ / ☒ / ☐	2/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/16/49	Mt. Calvery Cem.	Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
2/16/49	Huntington Williams, MD	Elroy O. Wilson	

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71620 ✓ 420.1 G71620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Samuel H. Jackson

2. DATE OF DEATH 2/14/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home 1292 William St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1297 William St. Balto. Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.
D. STREET ADDRESS (If rural, give location) 1292 William St 2-4-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	June-8	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel H. Jackson

14. MOTHER'S MAIDEN NAME Fannie E. Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Earl J. Jackson ADDRESS 92+ Elmridge Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension Cardiovascular Renal Disease.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 1, 1949 *to* Feb. 14, 1949 *that I last saw the deceased alive on* Feb. 14, 1949, *and that death occurred at* 1:15 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE N. B. Friedman M. D.

23B ADDRESS 1319 Eight St. - Balt. 30

23C DATE SIGNED 2-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 2-17-1949

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 16 1949

REGISTRAR'S SIGNATURE

25 FUNERAL DIRECTOR Flynn & Fleming ADDRESS 1426 Light St.

VS 150

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Clementine Gillis

2. DATE OF DEATH Feb. 13-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore Life Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1704 Etting Street 14-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Widowed	March 9-1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Henry W. Herbert

14. MOTHER'S MAIDEN NAME Jennie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Baltimore City Hospitals Records- ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	8 days
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Cerebral Vascular Accident	8 days
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-8- , 1949 *to* 2-13- , 1949, *that I last saw the deceased alive on* 2-13- , 1949, *and that death occurred at* 3.45A m., *from the causes and on the date stated above.*

23A. SIGNATURE W. D. Rogers M. D.

23B. ADDRESS Baltimore City Hospitals

23C. DATE SIGNED Feb. 13-1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 2/16/49

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn

24D. LOCATION (City, town, or county) (State) Baltimore Co.

DATE RECEIVED BY LOCAL REGISTRAR FEB 16 1949

REGISTRAR'S SIGNATURE Funeston Williams, M.D.

25. FUNERAL DIRECTOR Mrs. Geo. F. Holland ADDRESS 1631 Druid Hill Ave

VS 150

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71622 ✓ 331 G71622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Daisy B. Delcher

2. DATE OF DEATH: 2/14/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Charles Apartments 3333 N. Charles St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3333 N. Charles St. 1 7 07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Widowed	Sept. 7, 1874	74	5	6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	-----	Baltimore, Maryland	

13. FATHER'S NAME: Jacob Blankfard

14. MOTHER'S MAIDEN NAME: Elizabeth Ann MacIntosh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		James B. Martenet	3333 N. Charles

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage & paralysis — INTERVAL BETWEEN ONSET AND DEATH: 14 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis Hypertension — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Feb 1/49, 19__, to Feb 14, 1949, that I last saw the deceased alive on Feb 14, 1949, and that death occurred at 1 7 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter S. Tuttle M.D.		

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/14/49	Lorraine	oodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 16 1949	Huntington Williams, M.D.	H. C. Meeks and Son	805 N. Eutaw St.

VS 150

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G71623 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELIZABETH E. BROOKS

2. DATE OF DEATH Feb. 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1133 S. CLINTON ST.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY [redacted]
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D STREET ADDRESS (If rural, give location) 1133 S. CLINTON ST.

5. SEX	6 COLOR OR RACE	7 SINGLE, MARRIED WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years) last birthday	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
FEMALE	WHITE	MARRIED	Oct. 8, 1891	57	4	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
HOUSEWORK	AT HOME	BALTIMORE, MD.	

13. FATHER'S NAME RUDOLPH HAMILTON

14 MOTHER'S MAIDEN NAME ELIZABETH CURRY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
		WM. BROOKS	1133 S. CLINTON ST

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) METASTASIS, GENERALIZED	6 MOS
DUE TO	(B) CARCINOMA STOMACH	10 MOS.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
Dec. 15, 1948	CANCER STOMACH WITH GENERALIZED METASTASIS	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* OCTOBER, 1948 *to* FEB. 14, 1949 *that I last saw the deceased alive on* Feb. 13, 1949 *and that death occurred at* 2.50 A *m., from the causes and on the date stated above.*

23A. SIGNATURE, M. D.	23B ADDRESS	23C DATE SIGNED
Benjamin Hirshstein	124 S. HIGHLAND AVE	2/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
BURIAL	2-17-49	OAK LAWN CEM.	7225 EASTERN AVE.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 16 1949	Huntington Williams, M.D.	Charles L. Giles	901 S. CONKLING ST.

46B

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Weldon A. Robertson

2. DATE OF DEATH: 2/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1300 Hammer Court

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	Aug. 8, 1901	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed		Maryland	

13. FATHER'S NAME: William Robertson

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO

(B) Myocardial Infarction — 3 days

DUE TO

(C) Coronary Sclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 2/13 *1949 to* 2/15 *, 1949 that I last saw the deceased alive on* 2/15 *, 1949, and that death occurred at* 7.45 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allen Tilly Jr M. D.	South Baltimore General Hospital	2/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
REMOVAL	2/16/49	St. Paul's Cem.	Marion, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 16 1949	Huntington Williams, M.D.	Tilly & Zeiler	405 S. Wolfe St.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71625
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Truitt

2. DATE OF DEATH Feb. 14/49

3. PLACE OF DEATH
A. Baltimore City, Maryland 2857 Chesterfield Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Balto. (If outside corporate limits, write RURAL and give township) 22-01
D. STREET ADDRESS (If rural, give location) 2857 Chesterfield Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widow	May 7 1876	72	9	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Garwood
14. MOTHER'S MAIDEN NAME Emma K. Kirby
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Charlotte Metzger ADDRESS 2857 Chesterfield Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 Hrs
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertension — ?
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchiectasis

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/30 1949 *to* Feb 14, 1949 *that I last saw the deceased alive on* 2/14 1949 *and that death occurred at* 1:30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE Samuel Legum M. D.
23B. ADDRESS 126 E North Ave
23C. DATE SIGNED 2/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Feb. 17/49
24C. NAME OF CEMETERY OR CREMATORY London Pk. Cem.
24D. LOCATION (City, town, or county) (State) Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR FEB 16 1949
REGISTRAR'S SIGNATURE Cuthbert Williams, M.D.
25. FUNERAL DIRECTOR John A. Miller
ADDRESS 2334 Jefferson St.

839

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Georgia Lea Walker

2. DATE OF DEATH: Feb. 8, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 9 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 914 E. Pratt St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	W	Sep.	March 6, 1920	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		W. Va.	

13. FATHER'S NAME: John Walker

14. MOTHER'S MAIDEN NAME: Cora Trenum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			B. C. H. Records,	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Infectious Hepatitis	2 mos.
DUE TO (B)	Cirrhosis	?
DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 6, 1949 *to* Feb. 8, 1949, *that I last saw the deceased alive on* Feb. 8, 1949, *and that death occurred at* 3PM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	Baltimore City Hospitals	Feb. 15-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	FEB 16 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 16 1949	Huntington Williams, M.D.	Commissioner of Health	

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print)	SETH	PINKHAM	2. DATE OF DEATH February 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maine
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Augusta
D. STREET (If rural, give location): 87 Grove Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		May 25, 1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Marine Engineer		Addison, Maine	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Pinkham	Lottie Norton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
	020-12-8500	Mrs. L na Dow	87 Grove Street Augusta, Maine

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myocardial degeneration	
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
M.D.		2-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 18 1949	Mt. Pleasant Cem	Augusta Maine

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 16 1949	Huntington Williams, M.D.	Geo. K. Berger Jr	1578 Hollins St

VS 151

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CERTIFICATE CORRECTED 4-18-49 ✓ 4-22-1 G71628

G71628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Conrad D. Rippel

2. DATE OF DEATH 2/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 306 Lyndhurst St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 306 Lyndhurst St. 20-7

5. SEX Male

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) Widowed

8. DATE OF BIRTH (Sept. 7, 1869) 1860

AGE (In years last birthday) 79 88

If Under 1 Year: Months Days

If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Conrad Rippel

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mrs. Carl C. Ruhl, 306 Lyndhurst St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — 2 mo

DUE TO

(B) Arteriosclerotic cardio-vascular disease — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1947 *to* Feb. 14, 1949, *that I last saw the deceased alive on* Feb 14, 1949, *and that death occurred at* 6:00 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Roy M. Zimmerman M. D.

23B. ADDRESS 2858 Harford Rd.

23C. DATE SIGNED 16 Feb. 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Feb. 17/49.

24C. NAME OF CEMETERY OR CREMATORY Oaklawn

24D. LOCATION (City, town, or county) (State) Essex, Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 16 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Harry H. Nichter

ADDRESS 4101 Edmondson Ave

93D

1170

G71629

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71629

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Josephine M. Brosh

2. DATE OF DEATH: Feb. 15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 921 N. Collington Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

C. Length of stay in Baltimore: 63 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 921 N. Collington Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Nov 25, 1873	75	2 / 21	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housework		Bohemia	U.S.A.

13. FATHER'S NAME: Joseph Filip

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Julius Sitek	921 Collington Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Carcinoma Right breast (Pagets) — 8 mos

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 10, 1948 *to* Feb 15, 1949 *that I last saw the deceased alive on* Feb 14, 1949 *and that death occurred at* 1A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph Pokorny M. D.	2200 E Madison St	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	2-18-49	Holy Redeemer	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 16 1949	Huntington Williams, MD	Yaus-Graeden	

VS 150

50

G71630 420.1 G71630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Josephine Hirt

2. DATE OF DEATH: 14 Feb. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1835 Ashland Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1835 Ashland Ave 7-5

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Not known
9. AGE (In years last birthday): 65 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Grocery owner
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: John Hirt
14. MOTHER'S MAIDEN NAME: Anna Lever
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John Hirt ADDRESS: 837 W. Lafayette

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Wm. H. Kammer Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 14 Feb. 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-17-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto Md
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: FEB 16 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Hamm Brothers

Turnington Williams, M.D.

VS 151

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704 ✓ X

G71631

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71631

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Esther Dowe

2. DATE OF DEATH: February 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: Wicomico
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salisbury
D. STREET ADDRESS (If rural, give location): Spring Hill Rd, Rt #2

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. / Mos. / Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	7-30-15	33		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md.	

13. FATHER'S NAME: V. Benton Webster

14. MOTHER'S MAIDEN NAME: Viola Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pemphigus Vulgaris — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Malnutrition (secondary to (A))

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 10-24, 1948 *to* 2-16, 1949 *that I last saw the deceased alive on* 2-16, 1949, *and that death occurred at* 9 10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Haven W. Hopkins, M. D.	JOHNS HOPKINS HOSPITAL	Feb. 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 19-1949	Salisbury Md.	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 17 1949	Emily Jon Williams, M.D.	Holloway Co	Salisbury Md

VS 150

153

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G71632
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): (Carl) Charles (Schultz) Shultz

2. DATE OF DEATH: 2/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Anchor Hotel 4-1

5. SEX	6. COLOR OR RACE	7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	about 1892	about 56 57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: George Shultz
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Chas. R. Hess ADDRESS: 937 Gorsuch Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial degeneration
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 2/16/49

24A. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): Burial
24B. DATE: 2/17/49
24C. NAME OF CEMETERY OR ~~CREMATORY~~: Balto.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 151

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71633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

452.1 G71633

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): MARY A. CATLETT

2. DATE OF DEATH: Feb. 14 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 330 East 28th St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 330 East 28th Street 12-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widow	Dec. 11, 1859	89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Virginia	

13. FATHER'S NAME: John Oliver

14. MOTHER'S MAIDEN NAME: Catherine Greenstead

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	Mrs Alice Waight 330 E. 28th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute Dilatation of Heart	1 hr
DUE TO (B)	Arterio-Sclerosis	20 yrs
DUE TO (C)	Myocardiac Degeneration	25 yrs
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Senility	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1948 *to* Feb. 14, 1949, *that I last saw the deceased alive on* Feb 14, 1949 *and that death occurred at* 10 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert M. Foster M. D.	2824 St. Paul St.	Feb 15 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/17/49	Woodlawn	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 17 1949	Huntington Williams M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

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G71634

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71634

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ella Teresa Weatherley

2. DATE OF DEATH: Feb. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5000 York Road
c. Length of stay in Baltimore: About 75 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5000 York Road 29-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Fe.	White	Single	10/15/73	75yr.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Maryland	

13. FATHER'S NAME: James Wilson Weatherley

14. MOTHER'S MAIDEN NAME: Maria L. Ringgold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Grace C. eatherley	5000 York Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

(B) Arterio Sclerosis & Cerebral Hemorrhage

DUE TO

(C) Cerebral Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Emphysema Pulmonalis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/5/ , 1949 *to* 2/15/ , 1949 *that I last saw the deceased alive on* 2/15/ , 1949, *and that death occurred at* 10:00 AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ray E. Brown Jr. M. D.	1400 N. Caroline Street	2/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/18/49	St. Mary's	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 17 1949	Huntington Williams, M.D.	H. W. Meade and Son	505 N. Calvert St.

VS 150

939

✓ 163

G71635

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71635

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Barney Stein

2. DATE OF DEATH: 2-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Mt Sinai Convalescent Home

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt. Sinai Home

c. Length of stay in Baltimore: 44 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 4008 Spruce Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Widow	1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Russia	U.S.A.

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Samuel Stein -	6809 61st Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of right lung

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 1 1948 *to* Feb 17, 1949, *that I last saw the deceased alive on* Feb 16, 1949, *and that death occurred at* 5:45 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Kadin M. D.	2306 Eutaw Pl Balto Md	2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-17-49	Mt Carmel	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 17 1949	Century for Williams, M.D.	Jack Senis Inc -	2108 Eutaw Pl.

VS 150

47D

G71636

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71636

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. OLGA FOLDES

2. DATE OF DEATH: 2-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: 2 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 735 Devonshire Rd. 2-7-48

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Wid.	2-16-1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Hungary	

13. FATHER'S NAME: Morris Klein

14. MOTHER'S MAIDEN NAME: Lena

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Stephen Folder	735 Devonshire Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 5 days +
DUE TO
(B) Auricular fibrillation — 5 days +
DUE TO
(C) Arteriosclerotic cardiovascular disease — 4-5 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypertension.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	—	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 2-12-, 1949 *to* 2-16-, 1949 *that I last saw the deceased alive on* 2-15-, 1949, *and that death occurred at* 2:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allyn F. Smith, M.D.	Mercy Hospital	2-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	2-17-49	Baltimore Hebrew	Balto	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 17 1949	Hunting Tor Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

92

G71637

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71637

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HENRY SCHNEIDER

2. DATE OF DEATH: Feb. 15, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ardleigh Nursing Home 2075 Rockrose Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1388 W. North Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
male	white	widower	Oct. 2[illegible], 1868	80 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Frederick Schneider
14. MOTHER'S MAIDEN NAME: Anna P. Miller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. John H. Schneider ADDRESS: 6211 Gernand Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Anemia — INTERVAL BETWEEN ONSET AND DEATH: 2/11/49

DUE TO

(B) Chr. Parenchymatous Nephritis — 1945

DUE TO

(C) Chr. myocarditis — 1945

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 1 *,* 1949 *to* Feb 15 *,* 1949 *that I last saw the deceased alive on* Feb 15 *,* 1949 *, and that death occurred at* 2 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul Brown M. D.
23B. ADDRESS: 1663 W. North Ave
23C. DATE SIGNED: 2/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/17/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 17 1949
REGISTRAR'S SIGNATURE: Thurlington for Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICHNER & SONS
ADDRESS: Balto., Md.

VS 150

1212

G71638 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71638

1. NAME OF DECEASED (Type or Print): Jackson, Carl

2. DATE OF DEATH: 2-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland

c. Length of stay in Baltimore: Yrs. 4 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Tab: Dorchester
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): East New Market
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 51 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Jackson
14. MOTHER'S MAIDEN NAME: Frazer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Un Known
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Alvina Jackson
ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Alveolar cell Carcinoma of lungs — INTERVAL BETWEEN ONSET AND DEATH: 8 Mo

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Un Known

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Subtotal gastrectomy — 5 yrs

19A. DATE OF ~~OPERATION~~ Autopsy
19B. MAJOR FINDINGS OF OPERATION: Carcinomatosis of Lungs
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-12-, 1949, *to* 2-16, 1949 *that I last saw the deceased alive on* 2-15-, 1949. *and that death occurred at* 2 00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Milford Tapper M. D.
23B. ADDRESS: University Hosp.
23C. DATE SIGNED: 2-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feby 19/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Cambridge Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 17 1949
REGISTRAR'S SIGNATURE: Lurtington Williams, M.D.
25. FUNERAL DIRECTOR: John O. Mitchell Sons
ADDRESS: 1900 Eutaw Place

VS 150

47D

✓ 490

671639

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 671639

BIRTH NO. B.C.49-00249

1. NAME OF DECEASED (Type or Print): Melvin Wonser Mason

2. DATE OF DEATH: Feb 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1333 Brunt St.

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1333 Brunt St — 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	Col.	Single	Jan. 12/49	6 wks	1 / -	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unemployed		Md.	U.S. ✓

13. FATHER'S NAME: Bernard Mason

14. MOTHER'S MAIDEN NAME: Ida Reeves

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Ida Reeves	1333 Brunt St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Lobar Pneumonia (Left)	3
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Common Cold.	
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
/	/	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
/	/	/

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
/ m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	/

22. *I hereby certify that I attended the deceased from* 2/9, 1949, *to* 2/12, 1949, *that I last saw the deceased alive on* 2/12, 1949, *and that death occurred at* 5:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[illegible] Phillips M. D.	1543 Fenmore Ave	2/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	2/16/49	Mt Calvary	Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 17 1949	Huntington Williams, M.D.	A. Halstead	918-

VS 150

108

✓ 334

G71640
BIRTH NO

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71640

1. NAME OF DECEASED (Type or Print): Estilla Davis Fehsenfeld
2. DATE OF DEATH: Feb 17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 647 W Lanvale St Phy
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at her home
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 647 W Lanvale St Phy 12-7

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Sept 23 1861
9. AGE (In years last birthday) / If Under 1 Year: Months Days / If Under 24 Hours: Hours Min.: 87-4-25

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Thos Davis
14. MOTHER'S MAIDEN NAME: Katherine Rorke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: no
17. INFORMANT: Mrs Theo Mattbai
ADDRESS: Hayelton Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1½ hours.
DUE TO
(B) Hypertension — years.
DUE TO
(C) Cortico-Sclerosis - generalized — years.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1945 *to* Feb 16, 1949, *that I last saw the deceased alive on* Feb 16, 1949, *and that death occurred at* 8:45 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry M. Hamman M.D.
23B. ADDRESS: 20 E. Preston Street
23C. DATE SIGNED: 2/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-19-49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 17 1949
REGISTRAR'S SIGNATURE: Thurlow for Williams, M.D.
25. FUNERAL DIRECTOR: Stewart & Morris
ADDRESS: Balto.

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G71641 ✓ 170 G71641

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Grace Bay Simmons Legg

2. DATE OF DEATH Feb. 15 49

3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Broadway Johns Hopkins Hospital

c. Length of stay in Baltimore Yrs. 19 Mos. - Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY Baltimore City C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore Md. D. STREET ADDRESS (If rural, give location) 151 W. Lanvale St

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 3-27-1880

9. AGE (In years last birthday) 68 yrs. If under 1 Year: Months, Days. If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Alfred A. Simmons

14. MOTHER'S MAIDEN NAME Mary E. Bay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service) No

16. SOCIAL SECURITY NO None

17. INFORMANT Johns Hopkins Hospital ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Carcinoma of breast DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 27, 1949 *to* Feb. 15, 1949 *that I last saw the deceased alive on* Feb 15, 1949, *and that death occurred at* 4:25 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE John B. Crow M. D.

23B ADDRESS Johns Hopkins Hospital

23C. DATE SIGNED 2/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Feb 17 49

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 17 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25 FUNERAL DIRECTOR Stewart & Mowen Co. ADDRESS 108 W. North Ave

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50 City #1.

G716:2 ✓ 151 [illegible]1642

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James A Brown

2. DATE OF DEATH: 2-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2016 Penn ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE 2016 Penn ave B. COUNTY City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto md

D. STREET ADDRESS (If rural, give location): 14-3

c. Length of stay in Baltimore: 40 Yrs. Mon. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
mo	Col	married	2/16/1891	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor		Budd Creek St Mary's Co	

13. FATHER'S NAME: Benjamin Rickson

14. MOTHER'S MAIDEN NAME: Lou Payne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	217-01-1328	Mary C Brown	Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — DUE TO

(B) Gastritis — DUE TO

(C) Anemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 mo

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Jno Hopkins Hospital	Carcinoma Gastric	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2-11 1949 *to* 2-15 1949, *that I last saw the deceased alive on* 2/15 1949, *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jno R Bordley M.D.	1133 W Mount	2/17/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Feb 19 1949	Mt Auburn	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 17 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR: V^a Brooks — ADDRESS: 1463 N Carey St

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G71643 154 G71643

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EMIL I. DROLL

2. DATE OF DEATH: FEB. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 431 N. Pulaski Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 431 N. Pulaski Street 20-1

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 1883
9. AGE (In years last birthday): 65
If under 1 Year: Months: Days
If under 24 hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: B.&O.R.R.

11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Adolph Droll
14. MOTHER'S MAIDEN NAME: Marian Wise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Elizabeth Droll ADDRESS: 431 N. Pulaski St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO
(B) Carcinoma of rectum — 5 1/2 years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1943
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of rectum
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August, 1943 *to* Feb 14, 1949 *that I last saw the deceased alive on* Feb 14, 1949, *and that death occurred at* 11:30A. *from the causes and on the date stated above.*

23A. SIGNATURE: Wm. Michel, M. D.
23B. ADDRESS: 2901 Edmondson Ave
23C. DATE SIGNED: Feb 17 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 17-49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn Cemetery Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 18
REGISTRAR'S SIGNATURE: [illegible] M.D.
25. FUNERAL DIRECTOR ADDRESS: F.B.WIPPERT & SON..1300 EUTAW PL.17

461

VS 150

G71644

M.M. 126782

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71644

Registered No.

1. NAME OF DECEASED (Type or Print) William E. Thomas

2. DATE OF DEATH Feb. 14-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1437 Parrish St Balto. Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md
D. STREET ADDRESS (If rural, give location) 1437 Parrish ST. 15-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Col.	Widowed	?	75 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unknown	?	Balto. Md	U.S.

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
unknown	?	B.C.H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypertension	
DUE TO	Cardiovascular Disease?	?
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Cystic Disease of the Kidneys	Life
DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT (C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 10- , 19 49 *to* Feb. 14- , 19 49 *that I last saw the deceased alive on* Feb. 14, 19 49 *, and that death occurred at* 8.00 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	4940 Eastern Avenue	2-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/17/49	West Lawn	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 17 1949		Geo. H. Kelson	1313 Presstman St

VS 150

937

✓ 442

G71645

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71645

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Laura T. MARTIN – MORAN

2. DATE OF DEATH Feb. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2511 Arbutus Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore whole life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-42

D. STREET ADDRESS (If rural, give location) for past two years 2511 Arbutus Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
fem.	white	widowed	June 2, 1866	82	8	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME William Marran

14. MOTHER'S MAIDEN NAME Rose -- unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Son Jos. Jurline ADDRESS 2511 Arbutus Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral hemorrhage	4 weeks
DUE TO (B)	Hypertensive Cardio-vascular-renal disease	
DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1949, *to* February, 1949 *that I last saw the deceased alive on* Feb. 10, 1949, *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Gertrud Sonnenfeld M. D.

23B. ADDRESS 2708 Hollins Ferry Road

23C. DATE SIGNED 2/17.49.

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE 2-21-49

24C. NAME OF CEMETERY OR CREMATORY Fowlsdon Park

24D. LOCATION (City, town, or county) (State) Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR FEB 17 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR ADDRESS Edward Fowlsdon 2309 Gwynn Falls Blvd

VS 150

131a

G71646 ✓ + 761.0 G71646

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C.49-02845 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Hewitt (383362)

2. DATE OF DEATH: February 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middle River P.O.
D. STREET ADDRESS (If rural, give location): New Philadelphia Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Single	2-10-49			2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Hewitt
14. MOTHER'S MAIDEN NAME: Lillian Steven

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lillian Hewitt ADDRESS: New Philadelphia Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) anoxia
DUE TO
(B) ante-partum bleeding
DUE TO
(C) Placenta previa

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February 10, 1949 *to* February 10 1949 *that I last saw the deceased alive on* February 10 1949 *and that death occurred at* 6:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Glen G. Rice M. D.
23B. ADDRESS: 601 North Broadway
23C. DATE SIGNED: 2-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: FEB 17 1949
REGISTRAR'S SIGNATURE: Catherine Williams, M.D.
25. FUNERAL DIRECTOR:
ADDRESS:

VS 150

160 c

G71647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71647

BIRTH NO. B.C. 49-03013

1. NAME OF DECEASED (Type or Print): Baby "Boy" Loney

2. DATE OF DEATH: FEB 12 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 1235 Eager St 10-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored		2-11-49			2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Esander Loney

14. MOTHER'S MAIDEN NAME: Helen Irby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Prematurity	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-11-, 1949, *to* 2-12-, 1949, *that I last saw the deceased alive on* 2-12-, 1949, *and that death occurred at* 7:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P. Mavroon M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Loney Burial	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 17 1949	Registrar for Williams, M.D.		

VS 150

159

✓ 401.1

716:8

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

716:8

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) MRS. ADALYN WIRTH — ADALYN MATHILDA WIRTH

2. DATE OF DEATH 2/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME

c. Length of stay in Baltimore — Yrs. Life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2012 RAMBLEWOOD 27-38

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH Nov. 19, 1900
9. AGE (In years last birthday) 48 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JOHN TUERK

14. MOTHER'S MAIDEN NAME Margaret Auhl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT MR. WM. H. WIRTH. ADDRESS 2012 Ramblewood Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mural Thrombosis
DUE TO Auricular Fibrillation & Mitral Stenosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rheumatic Fever
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT — Atelectasis Rt. Lower Lobe CPC.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/10 19 49 *to* 2/16 19 49 *that I last saw the deceased alive on* 2/16 19 49 *and that death occurred at* 3:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Ernest H. Mintz M. D.
23B. ADDRESS Church Home
23C. DATE SIGNED 2/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 2/19/49
24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 17 1949
REGISTRAR'S SIGNATURE Initials for Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND 9-18

G71649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71649

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Chaffin

2. DATE OF DEATH: Feb. 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Univ. Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 131 West West Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	B	Separated	April 28, 1917	31	9	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maid

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Robert Gillans

14. MOTHER'S MAIDEN NAME: Mary Gillans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mary Gillans — ADDRESS: 1812 Bona ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Obstruction of Ureters — 3 wks.

DUE TO

(C) Ca cervix — 8 months

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 4, 1949, *to* Feb 14, 1949, *that I last saw the deceased alive on* Feb 14, 1949, *and that death occurred at* 6:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: K. C. Hunter M. D. M. D.

23B. ADDRESS: University Hosp.

23C. DATE SIGNED: 2-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: February 18, 1949

24C. NAME OF CEMETERY OR CREMATORY: Mount Auburn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR: FEB 17 1949

REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Joseph A. Lively 661 West Baltimore St

VS 150

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G71650 CERTIFICATE CORRECTED 3-8-49 ✓443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71650

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Luke Dorsey Stone

2. DATE OF DEATH: February 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 315 S. Charles St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none
c. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3923 Canterbury Road 12-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	~~Feb. 15, 1949~~ April 9, 1901	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
warehouseman	tobacco	St. Mary's County, Md.	U. S.

13. FATHER'S NAME: James Joseph Stone

14. MOTHER'S MAIDEN NAME: Nannie Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Mrs. Florence Gibson Stone-3923 Canterbury

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Probable Massive Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 - 2 MIN.

DUE TO

(B) Cerebral and General Arteriosclerosis — 5 yrs ±

DUE TO

(C) ~~Hypertensive Cardio-Vascular Dis.~~ Hypertensive Cardio-Vascular Dis — 15 yrs ±

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov. 19, 1948, *to* Feb. 15, 1949, *that I last saw the deceased alive on* Feb. 1, 1949, *and that death occurred at* 4.10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert W. Garis M. D.	1103 St. Paul St.	2/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	2/18/49	Druid Ridge	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 17 1949	waiting for Williams, M.D.	John O. Mitchell & Sons, Inc. 1900 Eutaw Pl.

MB Mitchell

Dr. Garis 2 P.M.

93 D

G71651 Mar 7 ✓ x 753.1 G71651

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Calvin F. Ford

2. DATE OF DEATH: FEB 17 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Cecil
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elkton
D. STREET ADDRESS (If rural, give location): RFD #1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		11-10-36	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Boy		Md	

13. FATHER'S NAME: John Fletcher Ford

14. MOTHER'S MAIDEN NAME: Carrie M. Ford Creswell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
				JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Congenital Stenosis of Aqueduct of Sylvius	12 yrs
DUE TO (B)		
DUE TO (C)	Internal hydrocephalus Meningitis	2 mos.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12/15/48 1/29/49	Internal hydrocephalus	YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-9-, 1948 *to* 2-17-, 1949, *that I last saw the deceased alive on* 2-17, 1949, *and that death occurred at* 1:15 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Maurice Slater	JOHNS HOPKINS HOSPITAL	2/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-19-49	Methodist	North East Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 17 1949	Lexington Williams, M.D.	Joseph R. Grant	North East Md

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M M. 124055
G71652
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 443

Registered No. G71652

1. NAME OF DECEASED (Type or Print) Hennie Boyd (HENIRETTA)

2. DATE OF DEATH Feb. 16-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore Two Yrs (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 1617 N. Monroe ST. 15-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Married	Feb. 22, 1892	56 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.

13. FATHER'S NAME: William White

14. MOTHER'S MAIDEN NAME: Fannie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		B.C.H. Records	4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral vascular thrombosis	2 mos.
	DUE TO	
ANTECEDENT CAUSES	(B) Cerebral arteriosclerosis	3 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C) Hypertensive arteriosclerotic cardiovascular disease	3 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Bronchopneumonia, terminal	3wks.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10.25. , 19 48 *to* Feb. 16 , 19 49 *that I last saw the deceased alive on* Feb 16 , 19 49 , *and that death occurred at* 6 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. S. Rogers M. D.	Baltimore City Hospitals	Feb. 16-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2-20-49	Brooks Chapel	Mutual Calvert Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 17 1949	Hunter Williams, M.D.	Samuel W. Sullivan Jr. Balto. Md

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

NF03.0

Registered No. G71653

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY M. CHOLEWCZYNSKI

2. DATE OF DEATH: February 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 611 S. East Street 26-11

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: JULY 25, 1942
9. AGE (In years last birthday): 6
If Under 1 Year: Months 6, Days 20
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SCHOOL-CHILD.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: HENRY S. CHOLEWCZYNSKI
14. MOTHER'S MAIDEN NAME: E. MARGARET DORN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO —
17. INFORMANT: HENRY S. CHOLEWCZYNSKI ADDRESS: 611 S. EAST AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fractured skull
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Shuck & Clinton Streets 26/11
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): February 15, 1949 4:25P. m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Pedestrian struck by truck

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L. Kaylor M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 2-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: FEB. 19, 1949
24C. NAME OF CEMETERY OR CREMATORY: SACRED HEART CEMETERY
24D. LOCATION (City, town, or county) (State): GERMAN HILL RD. BALTIMORE MD.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles S. Zeiler ADDRESS: 901 S. CONKLING ST.

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G71654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50.0 Registered No. G71654

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MRS. KATHERINE ESTELLA MAGNESS

2. DATE OF DEATH 2/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland ST. JOSEPH HOSP.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. JOSEPH HOSPITAL

c. Length of stay in Baltimore Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ABINGDON
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
F	W	W	10-26-70	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		ABINGDON, MD	U.S.A

13. FATHER'S NAME Agustus Treadwell

14. MOTHER'S MAIDEN NAME Katherine Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Miss Caroline Magness	Abingdon Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Appendectomy — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Arteriosclerotic C.V. Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2-11-49	Acute appendix	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/11/ 1949 to 2/15/ 1949, *that I last saw the deceased alive on* 2/15/ 1949, *and that death occurred at* 6:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Daniel Ehrlich M.D.	St Joseph Hosp.	2/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	St. Francis	Abingdon Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 17 1949	[illegible]	Howard E. McComas & Son	Abingdon Md

VS 150

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71655

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71655

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Jenkins

2. DATE OF DEATH: 2/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1311 Bayard 21-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	C	Married	Feb. 8, 1897	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Savannah, Ga.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Jenkins
14. MOTHER'S MAIDEN NAME: Caroline Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Marie Jenkins, ADDRESS: 1311 Bayard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema
DUE TO
(B) Acute Congestive Heart Failure -
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 2/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/18/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 17 1949
REGISTRAR'S SIGNATURE: [signature] Registrar for Williams, M.D.
25. FUNERAL DIRECTOR: Chas. H. Kerfin ADDRESS: 512 Cavendish Ave.

VS 151

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G71656 BALTIMORE CITY HEALTH DEPARTMENT G71656

CERTIFICATE OF DEATH 422

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) MARSELLA BAFFORD

2. DATE OF DEATH February 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2852 Rayner Avenue
c. Length of stay in Baltimore 59 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 2853 Rayner Avenue 16-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Married	May 16, 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	America

13. FATHER'S NAME John Cardwell

14. MOTHER'S MAIDEN NAME ? Larkin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
		Daughter - Mamie L Lewis	2852 Rayner Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Degeneration
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L Royer M.D. | 23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED Feb. 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Fb 19-49	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 17 1949	[illegible] Williams, M.D.	John R Kenney	5635 Ashbourne Rd.

VS 151

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G716:57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G716:57

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SARAH M MAHER.

2. DATE OF DEATH FEBRUARY 17.1949

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE CITY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) KIRKLEIGH VILLA

c. Length of stay in Baltimore 1 YEAR. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE WASHINGTON B. COUNTY DISTRIC OF COLOMBIA

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
FEMALE	WHITE	SINGLE.	OCTOBER.20.1859	89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	NONE		U.S.

13. FATHER'S NAME Dennis Maher

14. MOTHER'S MAIDEN NAME Rita Fennon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CHRONIC MYOCARDITIS FEBRUARY 14 1949.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARTERIOR SCLEROSIS 1949.

DUE TO

(C) SENILTY

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

NONE

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE	NONE	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* FEBY 14 1949, *to* FEBY 17, 1949 *that I last saw the deceased alive on* FEBY 17, 1949, *and that death occurred at* 1.30P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles F Blanton M.D.	3013 ST PAUL STREET.	FEBY 17 194

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	MT OLIVET	WASHINGTON DC.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Chester for Mattiques, M.D.	Jas. Gardner Son	1756 Pa. Ave NW WASH. DC.

422.1

936

671658 ✓ X 671658

BALTIMORE CITY HEALTH DEPARTMENT 704.0

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) THEODORE HOVARDAS

2. DATE OF DEATH 2-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE DELAWARE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) WILMINGTON

D. STREET ADDRESS (If rural, give location) 1206 SMALLCROSS AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	2-22-1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
COOK	RESTAURANT	TURKEY	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
FORTIS DEC.	HELEN DEC.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Overwhelming Toxemia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

(B) Acute Lymphatic Leukemia 9 weeks

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2/11/49	Sternal Biopsy	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-28, 1949 *to* 2-17, 1949 *that I last saw the deceased alive on* 2-17, 1949, *and that death occurred at* 9A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Stephen K. Paduris M. D.	St. Agnes Hospital	2/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Feb. 18. 1949	Wilmington, Delaware	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams, M.D.	Joseph R. Grant	North East Md.

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0671639 ✓142.1 0671639

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ernest Albert Betz
2. DATE OF DEATH: Feb. 17, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2642 Linguette St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1300 W. Clement St. 23-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	White	Widower	May 14, 1871	77	9	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Night Watchman	Chamber of Commerce	Baltimore, Md.	

13. FATHER'S NAME: Edward A. Betz
14. MOTHER'S MAIDEN NAME: Sophia Bender

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No		Ernest R. Betz.	1105 Woodbourne Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, left parotid gland with extension to brain, left. — INTERVAL BETWEEN ONSET AND DEATH: 12 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov. 1948	Extensive cancerous involvement of neck + left ear.	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None	None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	None

22. *I hereby certify that I attended the deceased from* Feb. 13, 19 49 *to* Feb. 17, 19 49, *that I last saw the deceased alive on* Feb. 16, 19 49, *and that death occurred at* 5 30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Carl Myers, M. D.	1533 E. Coldspring Lane. Balto. 14 Md.	Feb. 17, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams, M.D.	William Cook, Inc.,	1217 St. Paul St.

VS 150

55E

CERTIFICATE CORRECTED 2-26-49

G71660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71660

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Daniel Grayson Grumbine

2. DATE OF DEATH Feb. 15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4506 Frederick Ave. Colonial Nursing Home
C. Length of stay in Baltimore 50 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3708 Harlem Ave. 16 08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	W.	Widowed	July 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Grumbine	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Hazel ~~Fehley~~ Feehley	3708 Harlem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Coronary Sclerosis

DUE TO

(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: 5 min. / ? / year

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec, 19 48 *to* 2-15, 19 49 *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William L Fleming M.D.	3025 Belair Road	2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 18/49.	New Cathedral, 4300 Old	Frederick Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 17 1949	Emerson Williams, M.D.	Harry H. Weitzke	4101 Edmondson Ave.

94a

G71661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 776

Registered No. G71661

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Baby Girl Ross

2. DATE OF DEATH 2/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.
C. Length of stay in Baltimore ~~Yrs.~~ ~~Mo.~~ 1 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 114 Haney Sucks St. 22

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F.	Negro	S	2/5/49				2	20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Maryland	U.S.

13. FATHER'S NAME Frank Tabb

14. MOTHER'S MAIDEN NAME Lois Chana Ross.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT Mother ADDRESS (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pre maturity 24 wks.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	no	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/5, 1949 *to* 2/5, 1949 *that I last saw the deceased alive on* 2/5, 1949 *and that death occurred at* 3:20 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry L. Leigh, M. D.	University Hosp.	2/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		University Medical School	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	26. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams, M.D.	Commissioner of Health	

FEB 16 1949

VS 150

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71662 B.C. 48-2320

BALTIMORE CITY HEALTH DEPARTMENT 752 G71662

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Donald Dorsey Jr

2. DATE OF DEATH: 2-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp
c. Length of stay in Baltimore: 3 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 13-C 3
D. STREET ADDRESS (If rural, give location): 2502 Francis St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	S	10-23-48		3	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INFANT.		Univ. Hosp	U.S.

13. FATHER'S NAME: Donald Dorsey Sr.

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Hydrocephalus

DUE TO C

(B) Bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
None		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-9-49, 19__, *to* 2-10, 1949, *that I last saw the deceased alive on* 2-10, 1949, *and that death occurred at* 4 P.M. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. H. Douglas Jr M. D.	Univ. Hosp.	2-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		University Medical School	FEB 16 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams, M.D.	Commissioner of Health	

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G71663 B.C. 49-08047 BALTIMORE CITY HEALTH DEPARTMENT 776 G71663

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Richard Gene Friesland
2. DATE OF DEATH: Feb 13, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY BALTO
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middle River
c. Length of stay in Baltimore: 12 hrs (Yrs. Mos. Days)
D STREET ADDRESS (If rural, give location): 12 Compass Rd
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Feb 13, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Roy Gene Friesland
14. MOTHER'S MAIDEN NAME: Marguerite Mary Pellicone
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother — ADDRESS: 12 Compass Rd. M.R.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-13-49, 19__, *to* 2-13-49, 19__, *that I last saw the deceased alive on* 2-13-49, 19__, *and that death occurred at* 7PM *m., from the causes and on the date stated above.*

23A. SIGNATURE: Bowie Linn Grant, M. D.
23B. ADDRESS: WBGH Dukeland & Baumer Sts.
23C. DATE SIGNED: 2/6 14 '49
24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School
24D. LOCATION (City, town, or county) (State): FEB 17 1949
ADDRESS:
DATE RECEIVED BY LOCAL REGISTRAR: FEB 18 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Commissioner of Health

VS 150

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159

G71664

BALTIMORE CITY HEALTH DEPARTMENT 376 G71664
BIRTH NO. B. C. 49-03290 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Antoinette Laverne Kalafos
2. DATE OF DEATH Feb 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto General Hosp.
c. Length of stay in Baltimore 6 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 3201 W North Ave 15 06

5. SEX female
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH Feb 9, 1949
9. AGE (In years) last birthday | If Under 1 Year: Months Days | If Under 24 Hours: Hours 17 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Louis Samuel Kalafos
14. MOTHER'S MAIDEN NAME Ira Lee Owens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Mother ADDRESS 3201 W North Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Feb 9 1949, 19__, *to* Feb 10 49, 19__, *that I last saw the deceased alive on* 9 AM 2-10, 1949, *and that death occurred at* 9 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE Bowie Linn Grant M. D.
23B. ADDRESS 1830 E. Fairfield and Rayner Sts
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY Johns Hopkins Medical School
24D. LOCATION (City, town, or county) (State) FEB 17 1949

DATE RECEIVED BY LOCAL REGISTRAR FEB 18 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR ADDRESS Commissioner of Health

VS 150

159

G71665

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71665
Registered No.

1. NAME OF DECEASED (Type or Print): JOHN C. RIEDMAN (REIDMAN)

2. DATE OF DEATH: 2-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 21 S. CURLEY ST.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 21 S. CURLEY ST. 1-0 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	MARRIED	7-13-1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ANDREW RIEDMAN
14. MOTHER'S MAIDEN NAME: WILHELMINA PERSHON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS: MRS JOSEPHINE RIEDMAN

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiovascular Renal Dis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1937, 19__, to Feb 17, 1949, *that I last saw the deceased alive on* Feb 17, 1949, *and that death occurred at* 1P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward A. Kallins M. D.	1847 W. Mount Ave	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	2-19-49	BALTIMORE NATIONAL	FREDERICK RD, MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
FEB 18 1949	Huntington Williams, M.D.	JOHN F. DENNIS INC 715 LIGHT ST -30

VS 150

131a

G71666

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71666

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lillian G. Ramsey

N 803.0

2. DATE OF DEATH: 2/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Ba
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 123 Murdock Rd.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: JUNE 12, 1881
9. AGE (In years last birthday): 67
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: AUGUST BECKER
14. MOTHER'S MAIDEN NAME: ELIZABETH KOENIG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS JACQUELYN LAUTENBERGER ADDRESS 123 MURDOCK RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of Skull
DUE TO
(B) intra cranial hemorrhage
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Allendale and Edmondson Sts.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 2 16 49 5P approx. p. m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by streetcar

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Emil L. Beyer M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 2/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: FEB. 19'49
24C. NAME OF CEMETERY OR CREMATORY: LOUDON PARK
24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: 2-19-49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Wyke
ADDRESS: 4101 Edmondson Ave

1710

VS 151

G71667 332 G71667

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): BERNARD B. BLOOMBERG
2. DATE OF DEATH: 2-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale Aged Home
c. Length of stay in Baltimore: 43 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3016 Oakford Avenue 27 6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	Feb 28, 1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Vest Operator		Russia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Israel Bloomberg	Anna Mears

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mrs Lena Bloomberg	3016 Oakford Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — DUE TO

(C) — DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-3, 1947, *to* 2-17, 1949, *that I last saw the deceased alive on* 2-17, 1949, *and that death occurred at* 4p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Nagel M. D.	Levindale Home	2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-18-49	Hebrew Friendship	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams, M.D.	Levinson Bros,	1126 W North Avenue

VS 150

836

G71668
W. B. 126324

CERTIFICATE CORRECTED 8-26-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71668
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Abraham Hicks

2. DATE OF DEATH: Feb. 16-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 76 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1355 N. Stricker ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	col	Married	July 8, 1872	76 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	✓

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			B.C.H. Records 4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Broncho-pneumonia	
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Metastatic Carcinoma of the inguinal regions bi-laterally ~~and lung~~	2 Mos. over
	DUE TO	
	(C) Primary tumor site unknown	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 24 *, 1949, to* Feb. 16 *, 1949 that I last saw the deceased alive on* Feb. 16 1949 *, and that death occurred at* 12.30 *m. from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	Baltimore City Hospitals	2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Feb 21	Mt. Auburn	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams, M.D.	A. Adolphus Holstead	918 55E

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Levin J. Walter

2. DATE OF DEATH: Feb 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 5412 Tramore Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5412 Tramore Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	Oct. 2, 1857	91	4 / 14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer retired	Farm	Maryland	

13. FATHER'S NAME: George Walter

14. MOTHER'S MAIDEN NAME: Sarah Walter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No.		Mrs. Roland Marshall 5412 Tramore Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Cerebral Thrombosis

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept. 1947 *to* Feb 16, 1949, *that I last saw the deceased alive on* Feb 15, 1949 *and that death occurred at* 1 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas J. Brennan M.D.	5217 Harford Road	2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Feb 13, 1949	St. Mary's	Tyaskin, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	[illegible]	C.G. Messick	Bivalve, Md.

VS 150

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G71670

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

442

G71670

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): MABELLE V. SHAW?

2. DATE OF DEATH: Feb. 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3044 Mathews St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 35 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3044 Mathews St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Married	June 23, 1875	73,	7 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home		Booton, N.J.	

13. FATHER'S NAME: Louis Fountaine

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No.		Mr. Walter C. Shaw	3044 Mathews St.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertension, Cardio-vascular, Renal disease	5 YRS.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 29 OCT., 1946 *to* FEB. 15, 1949, *that I last saw the deceased alive on* FEB. 15, 1949, *and that death occurred at* 5:10 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Lloyd E. Saylor M. D.	3902 Greenmount av.	FEB. 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	Feb. 18, 1949	Greenmount Crematory	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 16 1949	Huntington Williams, M.D.	Ullrich Funeral Home 2008 Orleans St.,

VS 150

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G716?1 5610 G716?1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH WARREN TILLEN

2. DATE OF DEATH: FEBRUARY 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPHS HOSPITAL

c. Length of stay in Baltimore: 85 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: NONE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1205N. ELLWOOD AVENUE 8 02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	WIDOWED	8/28/64	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		MARYLAND	U.S.A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
NO				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	UREMIA	
DUE TO (B)	GANGRENE OF THE ILEUM	15 hours
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	STRANGULATED INGUINAL HERNIA	"24 hours
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
FEB. 15 1949	GANGRENOUS INTESTINES, INGUINAL HERNIA	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* FEBRUARY 15 1949 *to* FEBRUARY 16 1949, *that I last saw the deceased alive on* FEBRUARY 16 1949 *and that death occurred at* 4:35 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Eugene L. Riley M. D.	ST JOSEPH'S HOSPITAL	2/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 19, 1949	Woodlawn	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 18	Hunting for Williams, M.D.	Ulrich Funeral Home 2008 Orleans St.,

VS 150

122a

G71672 ✓442 G71672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Anna R. Michel

2. DATE OF DEATH: Feby 16-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Balto B. COUNTY Balto Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 1208 Homewood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	Aug 3.	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Balto	

13. FATHER'S NAME: Henry Michel

14. MOTHER'S MAIDEN NAME: Caroline Emmert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Mrs Frederick Haas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular - Renal Disease with left ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: at least 9 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Hypertension — at least 9 yrs

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1949 *to* Feb, 1949, *that I last saw the deceased alive on* 15 Feb, 1949 *and that death occurred at* 8 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C. DATE SIGNED
Samuel Silverfield M. D.	714 E. Preston St	17 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 18/49	Baltimore	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR ADDRESS
FEB 18	Huntington Williams, M.D.	Ullrich Funeral Home 2008 Arlington Ave

VS 150

131a

G71673 ✓331

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71673

1. NAME OF DECEASED (Type or Print): Mrs. Anna I. Trabert
2. DATE OF DEATH: 2-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 36 S. East Ave 10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W	1-24-83	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md	U.S.A.

13. FATHER'S NAME: Michael Connelly
14. MOTHER'S MAIDEN NAME: Catherine McDonough

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs Wm Jansen (daughter) same — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracranial Hemorrhag — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs
DUE TO
(B) Arteriosclerosis and hyper-tension
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-16- 1949, *to* 2-16- 1949, *that I last saw the deceased alive on* 2-16- 1949, *and that death occurred at* 12:25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allyn B. Judd M. D.	Mercy Hospital	2-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/21/49	Holy Redeemer Cemetery	Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
FEB 18 1949	[illegible]	Lilly & Zeiler, Inc. Baltimore, Md.

VS 150

83a

671674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

162

Registered No. 671674

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Philip Mathias Faith

2. DATE OF DEATH: February 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1117 W. 42nd Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 45 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1117 W. 42nd Street 13 07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	August 17, 1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Conductor	Baltimore & Ohio R.R.	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Faith	Maria Rae

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	705-07-4185	Mrs. Ethel C. Faith	1117 W. 42nd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Lung. — INTERVAL BETWEEN ONSET AND DEATH: 5 mo.

DUE TO

(B) & Generalized Carcinomatosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 19[illegible] *to* Feb 17, 19 49 *that I last saw the deceased alive on* Feb 17, 19 49 *and that death occurred at* 12:35 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lawrence H. Loomis M. D.	3711 Falls Rd	2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 19, 1949	Loudon Park	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

47D

Medical Examiner's Case 14200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71675

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES. E. PHILLIPS

2. DATE OF DEATH: February 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp

c. Length of stay in Baltimore: 51 YRS (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1953 W Mulberry St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	Oct 2 - 1885	63	4	14

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NIGHT FOREMAN
10B. KIND OF BUSINESS OR INDUSTRY: TYDOL OIL CO
11. BIRTHPLACE (State or foreign country): YORK PA
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: NOT KNOWN
14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS EDW PHILLIPS ADDRESS: 2516 DRUID PK DRIVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Coronary THROMBOSES — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs
DUE TO
(B) ARTERIOSLEROTIC HEART DISEASE
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Earl Royston
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-16, 1949, to 2-16, 1949, that I last saw the deceased alive on 2-16, 1949 and that death occurred at 6:33 P m., from the causes and on the date stated above.

23A. SIGNATURE: Benjamin Berdanosky M. D.
23B. ADDRESS: West Baltimore Gen'l Hosp
23C. DATE SIGNED: 2-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/19/49
24C. NAME OF CEMETERY OR CREMATORY: LOUDON PK Cemetery
24D. LOCATION (City, town, or county) (State): Fred Ave

DATE RECEIVED BY LOCAL REGISTRAR: FEB 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. R. Lembach
ADDRESS: 525 N. LYNDHURST ST

VS 150

939

VE 973

G716576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

N 968

G716576

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): ANDREW F. (YOUST) YOST

2. DATE OF DEATH: February 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 3516 Lyndale Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	White	Widowed	April 12, 1898	50 (1jm)				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	Bethlehem Steel	Portland, Oregon	USA

13. FATHER'S NAME: Frank P. Yost

14. MOTHER'S MAIDEN NAME: Priscilla W. Sandus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	World War I	214-18-3206	Frances M. Baker	3516 Lyndale Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation due to carbon monoxide poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Garage	Rear of 3562 Lyndale Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21F. HOW DID INJURY OCCUR?
February 15, 1949(?) m.		Automobile exhaust fumes

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
C. J. Jaklevic M.D.		2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
BURIAL	FEB 19 1949	LOUDON PARK	FREDERICK AVE MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Hunting for Williams, M.D.	Deppel Bros	1800 E LOMBARD ST.

VS 15f

163M

G71677

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1949

G71677

Registered No.

1. NAME OF DECEASED (Type or Print) (Mary Ellen Hicks) ELLA HICKS JONES

2. DATE OF DEATH 2/17/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 262 N. Bruce St. 19 yrs

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Married	Jan. 27, 1890	59		20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Charleston, W. Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS Mr. Lawrence E. Jones

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Gangrene of the left leg
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE M.D

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED 2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE February 21, 1949

24C. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery

24D. LOCATION (City, town or county) (State) Baltimore City, Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 18 1949

REGISTRAR'S SIGNATURE [illegible] for Williams, M.D.

25. FUNERAL DIRECTOR Joseph A. Lucy ADDRESS 66 W. Biddle St

VS 151

93D

16?8

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

Registered No. G716?8

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Boulding

2. DATE OF DEATH: Feb. 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — B. Delta md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md — B. COUNTY

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 925 Madison ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 925 Madison Ave

c. Length of stay in Baltimore: 2 8 yrs (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C		Feb 9 1878	~~70~~ 71	15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Roanoke, Va	

13. FATHER'S NAME: Moses Roger

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Sylvania Askew	925 Madison Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Arteriosclerosis 2 yr?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-11, 1949 *to* 2-15, 1949 *that I last saw the deceased alive on* 2-14 19 49 *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Atwell Jones M. D.	5-54 Dolphin St	2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	Mt. Calvary	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams M.D.	Mr. Geo. T. A. Gibson Sr.	1735 Druid Hill Ave

VS 150

83a

G71679

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71679

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dorothy MAE Lyles

2. DATE OF DEATH: February 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 319 N. Bruce St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 26 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 319 N. Bruce Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Single	Oct. 10, 1920	28	4	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Philadelphia, Pa.	America

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
O'Brien Wald Lyles	Blanche Carmichael

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	216-12-0851	Beatrice Sollers	319 N. Bruce St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis (For Advanced Unknown) — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 5, 1949, *to* Feb. 16, 1949, *that I last saw the deceased alive on* 2-14-, 1949, *and that death occurred at* 9:10 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard H. Hunt M. D.	163 W. Franklin St.	2-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 19, 1949	Arbutus Memorial	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Justine for Williams, M.D.	Mrs Katie R Williams	322 N Schroeder

VS 150

13B

671680

B.S.- 126662

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

491 Registered No. 671680

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henry Lindt

2. DATE OF DEATH: Feb. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D STREET ADDRESS (If rural, give location): 944 N. Duncan Street

5. SEX	6. COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widow	Nov. 13, 1885	63	3 / 4	

10A. USUAL OCCUPATION (Give kind of work done during greater part of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Nurse		Md.	U.S.

13. FATHER'S NAME: Fred Lindt

14 MOTHER'S MAIDEN NAME: Dorothy Earehart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT: RECORDS* BALTO CITY HOSPITALS ADDRESS 4940 Eastern av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 Days

DUE TO

(B) Pulmonary Infarct — 1 Day

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-6-49 *to* 2-17-49, *that I last saw the deceased alive on* 2-17-49, *and that death occurred at* 10:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
R. S. Rogers M. D.	4940 Eastern Avenue	2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2-19-49	Oak Hill	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Hunter for Williams, M.D.	Frank Brackbill & Sons	

VS 150

107

G71681 CERTIFICATE CORRECTED 3-A-49 E 9-4 G71681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH N 994.0

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MILTON M. FOSTER

2. DATE OF DEATH: February 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1542 Fulton Avenue 15 0 2

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 5/15/13
9. AGE (In years last birthday): 35
If under 1 Year: Months Days
If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Zebulan, N.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jervis Foster
14. MOTHER'S MAIDEN NAME: Lizzie B. Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Alma B. Foster
ADDRESS: 1542 N. Fulton Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic adhesive pericarditis with calcification	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Acute congestive heart failure	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): North Fulton Ave. 15/2
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 2 16 49 A 4:30
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Auto into fixed object

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes [ ] accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L Kruger M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 2-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Zebulon - N.C.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 18 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Charles R. Law
ADDRESS: 802 Mad. Ave.

VS 151

170c

G71682 — 422.1 ✓ — G71682

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Robert F.Taylor.

2. DATE OF DEATH: Feb.16,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 706 W.36th St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ---

C. Length of stay in Baltimore ---- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 706 W.36th St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
Male.	White	Widowed.	July 23,1856	92		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist,Retired.		Maryland.	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No.	---	---	William E.Taylor	3603 Parkside Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atherosclerotic CVD — DUE TO

(B) with Decompensation — DUE TO

(C) Generalized Atherosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: (A) ? (C) ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec, 1948, *to* Feb 16, 1949 *that I last saw the deceased alive on* Feb 16, 1949 *and that death occurred at* 3:2a.4 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lawrence Shumaker M. D.	3711 Fallsrd	2-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb.19,1949	Druid Ridge.	Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 18 1949	[illegible] Williams, M.D.	Paul E.Chenoweth Jr 3615-17 Cheatnut Ave.

VS 150

937

✓ 421.1

71683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71683 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William F. Learr

2. DATE OF DEATH: Feb 17th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2808 Bayonne Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1221 N. Patterson Park Ave E 04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Widowed	Sept 12th 1862	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Real Estate	Md	

13. FATHER'S NAME: William Learr

14. MOTHER'S MAIDEN NAME: Mary Burke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Learr ADDRESS: 1221 N Patterson Park Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Myocreditis	1 Day.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Aortic Regurgitation Arteriosclerosis.	2 yrs.
	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 15, 1949 *to* Feb. 17/49, *that I last saw the deceased alive on* Feb. 17, 1949 *and that death occurred at* 2:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. F. Singewald M. D.	1615 E. North Ave.	2-18-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 21st 1949	New Leatherdale	Fredrick Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams M.D.	Geo. B. Lesoon	1201-03 N. Patterson Park Ave

VS 150

92a

71684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4201

Registered No. G71684

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 W. CROSS ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 W. CROSS ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER E KERSHNER

3 (b) If veteran, name war: WORLD WAR II
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 15, 1901

8. AGE: Years	Months	Days	If less than one day
47	11	1	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation INSPECTOR
11. Industry or business GUNTHERS BREWERY

FATHER
12. Name LOUIS E KERSHNER
13. Birthplace MD

MOTHER
14. Maiden Name ELIZABETH HORNN
15. Birthplace MD

16 (a) Informant MISS BERTHA KERSHNER
(b) Address 721 W. CROSS ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 21 '49 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location BALTO MD

18 (a) Funeral director Harry N Wetzler
(b) Address 4101 Edmondson Ave Baltimore, MD

19 (a) [illegible] (Local registrar) Registrar

FEB 18 1949

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 16 1949, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9/49 19[illegible] Feb 16 19 49 and that I last saw h[illegible] alive on 2-16 19 49.

Immediate cause of death: Coronary Thrombosis — Duration: 1 day
Due to: Coronary Artery disease — 24 yrs
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 517 Scott St. Date signed 2/18/49

94a

VS 150

G71685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71685

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ARTHUR SNOW

2. DATE OF DEATH: February 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore City -

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

C. Length of stay in Baltimore: 50 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1312 William St. 24-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Married		74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Weatherstripping	Weatherstripping	Manchester N. H.	

13. FATHER'S NAME: Edmund Snow

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No Knowledge		Katie Snow	1312 William St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
A. P. Gilbert M.D.		2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/21/49	Baltimore Cemetery	North ave. Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Emily Jones Williams, M.D.	Frank H. Newell Inc.	

VS 451

937

Correct age is especially important. Physicians: please write the cause of death very carefully.

443

71686

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71686

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BENJAMIN KAUFMAN.

2. DATE OF DEATH: 2/18/1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 1736 N. Bentalou St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 74 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1736 N. Bentalou St. 15 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 1 Day: Hours, Min.
Male	White	Married	9/3/1874.	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Theater Office	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Henry Kaufman

14. MOTHER'S MAIDEN NAME: Sophie Rothschild.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT, ADDRESS
No		Mrs. Harry Baernstein, 3806 Grantley Road.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Myocardial Infaretion	1 hour
DUE TO (B)	Hypertensive Cardo vascular disease	20 yrs
DUE TO (C)	Generalized arteriosclerosis -	20 yrs
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	none	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
no	none	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	none	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/10, 1949 *to* 2/18, 1949, *that I last saw the deceased alive on* 2/18, 1949, *and that death occurred at* 3 15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Maurice Feldman Jr M. D.	817 St. Paul St.	2/18/1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/20/1949.	Baltimore Hebrew	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR, ADDRESS
FEB 18 1949	[illegible]	Harry Sonnenreich & Son. 1902 Eutaw Place.

VS 150

6

937

G71687
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71687
Registered No.

1. NAME OF DECEASED (Type or Print) PHILLIP JOHN OTTER	2. DATE OF DEATH Feb. 17, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 623 S. Paca St.	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
c. Length of stay in Baltimore Yrs. Mos. Days	D. STREET ADDRESS (If rural, give location) 623 S. Paca St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	Oct. 3, 1878	70 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
- shipping clerk	Automatic Lite Co.	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob J. Otter	Mary Bayer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		214-05-3085	Mrs. Bertha M. Otter	623 S. Paca St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic Myocarditis	Unknown
	DUE TO (B) Unknown (age ?)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ? , 1947 *to* Feb 16 , 1949 *that I last saw the deceased alive on* Feb. 12, 1949 *and that death occurred at* 6:20 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert V. Gaines M. D.	707 W. Hamburg St	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	Moreland Mem. Pk.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Courtney F. Williams, M.D.	WILLIAM J. TICKNER & SONS	Balto., Md.

FHS 1950

929

G71688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

Registered No. G71688

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Belle CORPEW O'Neal

2. DATE OF DEATH 2/18/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 33rd. Cabot Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore 27 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Florida
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gainesville
D STREET ADDRESS (If rural, give location) Route 5, 115 Palm Terrace

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
F	W	W	1/23/1880	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	Housewife	North Carolina (Robeson Co.)	U.S.A.

13. FATHER'S NAME William H. Corpew

14. MOTHER'S MAIDEN NAME MARIA McCallum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO no

17. INFORMANT John C. O'neal ADDRESS 115 Palm Terr. Gainesville Fla.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Cecum with metastases DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(INTERVAL BETWEEN ONSET AND DEATH) ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
1/28/49	Carcinoma of Cecum with metastasis	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/22, 1949 *to* 2/18, 1949 *that I last saw the deceased alive on* 2/18, 1949, *and that death occurred at* 8:40 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Tucker M. D.	Union Memorial Hospital	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	2/18/49		Melrose, Fla.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams M.D.	WM. J. TICKNER & SONS	Balto., Md.

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071689

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 071689

1. NAME OF DECEASED (Type or Print): HELEN NELLIE BERNER

2. DATE OF DEATH: Feb. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Astor Court Apts. 2436 St. Paul St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2436 St. Paul St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	Sept. 17, 1878	70 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John W. Lee	Mary A. Sinclair

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Mr. Robert L. Berner	Winnetka, Ill. 231 Church Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary thrombosis	24 hrs.
DUE TO (B)	Arteriosclerotic cardio-vascular disease	?
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 3, 1948 *to* Feb 16, 1949, *that I last saw the deceased alive on* Feb 16, 1949, *and that death occurred at* 2 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm N. McTaggart M. D.	1800 N. Charles St.	2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	New Cathedral Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Washington Williams, M.D.	W. J. TICKNER & SONS	Balto., Md.

VS 150

93D

G71690

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 420

G71690 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KENNARD CARLSON WEST

2. DATE OF DEATH: Feb. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 12 W. 24th St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 12 W. 24th St. 12 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	Married	July 22, 1906	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter		Chestertown, Md.	USA

13. FATHER'S NAME: Theodore West

14. MOTHER'S MAIDEN NAME: Martha J. Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no			Mrs. Mary C. West	12 W. 24th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — Interval between onset and death: instant

DUE TO

(B) Coronary occlusion — instant

DUE TO

(C) Coronary arteriosclerosis — Indefinite

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4 October, 1948, *to* 15 Feb, 1949 *that I last saw the deceased alive on* 12 Feb 1949 *and that death occurred at* 10:40 ? m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	2020 N Charles St	17 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 19, 1949	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	[signature]	W. J. TICKNER & SONS INC.	North & Pa. Ave

VS 150

94a

Correct age is especially important. Physician: please write the

G71691

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71691

BIRTH NO. 07

Registered No.

1. NAME OF DECEASED (Type or Print): MARION M. SOPER

2. DATE OF DEATH: Febyuary 17, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 15
D. STREET ADDRESS (If rural, give location): 3504 Cedardale Rd.

8a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3504 Cedaydale Road, 15

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Maried	Oct. 13, 1897	51	4 4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland (Balto.)	U.S.

13. FATHER'S NAME: Clarence E. Owen (deceased)

14. MOTHER'S MAIDEN NAME: Effie E. Michael (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Mr. Granville Soper (husband)	same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hodgekin's Disease — INTERVAL BETWEEN ONSET AND DEATH: 12 yeays
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
October 12 1948	Biopsy — Hodgekins Disease (University Hospity)	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* October 30, 1948 *to* Feb 17, 1949 *that I last saw the deceased alive on* Feb. 17, 1949 *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Millard T. Traband Jr. M. D.	3400 Woodline Ave, Balto 7, Md	2/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LOUIS FLEISCHER

2. DATE OF DEATH: Feb. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1729 Ellamont St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1729 Ellamont St. 1-66

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	widower	Aug. 1889	59 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
salesman		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	215-10-9248	Mrs. Ada Shephard	1729 Ellamont St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombosis Acute Coronary — INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO

(B) Sclerosis Coronary — INTERVAL BETWEEN ONSET AND DEATH: 4 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-24-, 1947 *to* 2-17-, 1949 *that I last saw the deceased alive on* 2-17-, 1949, *and that death occurred at* 3 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mendelis M. D.	651 N Bentalou	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams, M.D.	Wm. J. TICKNER & SONS	Balto., Md.

VS-150

94a

correct age is especially important. Physicians: please write plainly, use ink and do not abbreviate.

G71693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71693

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CATHERINE A. BELZ

2. DATE OF DEATH: Feb. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 125 E. Preston street

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 125 E. Preston street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	Single	AUGUST 20-1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home	---	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Peter E. Belz

14. MOTHER'S MAIDEN NAME: Sophia Kiel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	none	Mr. Harry Weaver	2 E. 21st street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute Coronary Occlusion	5 hours
DUE TO		
ANTECEDENT CAUSES. (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	Coronary Sclerosis	?
DUE TO		
(C)	Hypertension	?
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb 9, 1949 *to* Feb 16, 1949, *that I last saw the deceased alive on* Feb 9, 1949, *and that death occurred at* 7.30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas J. Mike M. D.	3900 Greenmount Ave	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 19/49	Holy Redeemer	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Secretary to the Registrar	Wm. E. Evans & Son, Inc.	118 West Mount Royal ave.

VS 150

94a

G71694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 760

G71694 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Wooten

2. DATE OF DEATH: 2/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1427 Myrtle Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	C		Sept 12-1903	45 4 4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor		A.A. Co Md	U.S.A.

13. FATHER'S NAME: Thomas Wooten

14. MOTHER'S MAIDEN NAME: Mary Mankey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Sola Wooten	1427 Myrtle Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetes Mellitus (Coma) — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: unknown

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/17, 1949, to 2/17, 1949 *that I last saw the deceased alive on* 2/17, 1949, *and that death occurred at* 8.50 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bobby L. Jones M. D.	Franklin Square Hospital	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/22/49	Township Md	A.A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949		Wm A Jackson	

VS 150

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G71695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71695

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Eva M. Paulus

2. DATE OF DEATH: 2/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 102 N. Chapel St. 604

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 102 N. Chapel St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	2/27/1871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper	Home	Maryland	U.S.A.

13. FATHER'S NAME: Jacob Paulus

14. MOTHER'S MAIDEN NAME: Margaretha ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: George Paulus ADDRESS: 102 Chapel St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2/16 2 or 3 days

DUE TO

(B) Chr. Myocarditis — July 1948

DUE TO

(C) Arterio Sclerosis — Jan. 1944

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Feb 1, 1949, to Feb 17, 1949, that I last saw the deceased alive on Feb 17, 1949, and that death occurred at 5a m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William E. Rykaert M. D.	801 W Lanvale St	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/21/49	Loudon Park	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 18 1949	Huntington Williams, M.D.	Tilly & Zeiler Inc	403 S. Wolfe St.

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Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G71696

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71696

BIRTH NO. Form No. 1 Registered No.

1. NAME OF DECEASED (Type or Print): Newton Lockwood

2. DATE OF DEATH: Feb. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1305 John St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 50 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1305 John St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	white	single		85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		Richmond, Va.	

13. FATHER'S NAME: Joshua W. Newton

14. MOTHER'S MAIDEN NAME: Ann Fitshugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Miss Ethel B. Lockwood	1305 John St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	1 hr.
DUE TO (B)	Hypertension	Unknown
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1922, *to* Feb 17, 1949, *that I last saw the deceased alive on* Feb 16, 1949, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	140 E. Lexington	Feb 17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	Hoolywood	Richmond, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 1949	[illegible] Fitzhugh, Va.	John O. Mitchell Sons	1900 Eutaw Place

VS 150

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G71697 G71697

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 491

Registered No.

1. NAME OF DECEASED (Type or Print): MR. WILLIAM HOWARD VOIGHT

2. DATE OF DEATH: 2-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2719 St. Paul St., Balt. 18

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 5-17-1860
9. AGE (In years last birthday): 88 | If Under 1 Year: Months 9, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William A. Voight
14. MOTHER'S MAIDEN NAME: Carlotta ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Harry L. McGinn ADDRESS: 119 E. 25th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A). Pneumonia, bronchial, bilateral — Interval between onset and death: 12 days
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Portic thrombosis (?) — 9 mo. ?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-6-49 19__, *to* 2-17-49, 19__, *that I last saw the deceased alive on* 2-17-49 19__ *and that death occurred at* 10.50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: James W. C. Finney M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-19-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemy.
24D. LOCATION (City, town, or county) (State): Fredericka ave

DATE RECEIVED BY LOCAL REGISTRAR: FEB 20 1949
REGISTRAR'S SIGNATURE: Beatrice Williams M.D.
25. FUNERAL DIRECTOR: John O. Mitchell & Sons ADDRESS: 1900 Eastern Ave

VS 150

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Street age is especially important. Physicians: please write the cause of death clearly and legibly.

G71698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 421.4

Registered No. G71698

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HUGH V. O'DONNELL

2. DATE OF DEATH 2/16/49

3. PLACE OF DEATH: A. Baltimore City, Maryland I732 Johnson Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) I732 Johnson Street 2-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
M	W	W	6/I0/I888	60	8	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stationary Engineer	Beth. Steel Co.	Baltimore	

13. FATHER'S NAME: James O'Donnell

14. MOTHER'S MAIDEN NAME: Mary Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	Navy		Family - Same	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Valvular Disease of the Heart
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1949 to Feb 15th 1949 *that I last saw the deceased alive on* Feb 15 1949 *and that death occurred at* 4 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis J. McGrath M.D.	IE. Randall Pl N	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	2/21/49	Glen Haven	Glen Burnie

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Huntington Williams, M.D.	James L. McCauley	- I30 E. Fort Ave.

VS 150

92D

Correct age is especially important. Physicians: please write and state duration of disease clearly and fully.

G71699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71699

BIRTH NO. 170

1. NAME OF DECEASED (Type or Print): KATHERINE GILLECE

2. DATE OF DEATH: 2/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 444 E. Clement St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 444 E. Clement Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months Days	If under 24 hours: Hours Min.
F	W	W	4/13/1876	72	10 . 2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Baltimore, Md.	

13. FATHER'S NAME: Timothy Welsh

14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Family -	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) General Carcinomatosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Malignancy of right breast — Diagnosis made at St Joseph Hosp April 1948

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 10, 1948, *to* Feb 15, 1949, *that I last saw the deceased alive on* Feb 15 1949 *and that death occurred at* 10:40 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. S. L. Barranco M. D.	436 E Fortaae Balt 30	2/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	Cathedral	Frederick Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Huntington Williams, M.D.	James L. McCauley	- 130 E. Fort Av

VS 150

50

G71700 443 G71700

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rose Forrest.

2. DATE OF DEATH: 2-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital
C. Length of stay in Baltimore: Yrs. 2 Mos. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 112 S. Monastery

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): D.
8. DATE OF BIRTH: 9-4-1899
9. AGE (In years last birthday): 49. Under 1 Year: Days 5 Hours 14 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Paul Brandhuber
14. MOTHER'S MAIDEN NAME: Mary Thompson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Family ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro Vascular Accident
DUE TO
(B) - Cerebral Hemorrhage - left
DUE TO
(C) Hypertension Cardio Vascular Renal
Long standing.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) a. m. p. m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 17, 1949 to 2-18, 1949 that I last saw the deceased alive on 2-18, 1949, and that death occurred at 12:45 A.M. from the causes and on the date stated above.

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): B.
24B. DATE: 2/21/49
24C. NAME OF CEMETERY OR CREMATORY: Woodland
24D. LOCATION (City, town, or county) (State): Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR: FEB 19 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: [illegible] ADDRESS: [illegible]

VS 150

93D

G71701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71701

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EMIL COENELL

2. DATE OF DEATH 2/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO. GENERAL HOSPITAL
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md. B COUNTY A.A.
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) JOINT PLEASANT, Md
D STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W		12/15/1890	58	2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10B. KIND OF BUSINESS OR INDUSTRY Self.
11. BIRTHPLACE (State or foreign country) Balto.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Arthur Coenell
14. MOTHER'S MAIDEN NAME Margaret Broan.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Family ADDRESS Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RESPIRATORY TRACT OBSTRUCTION — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) SEMINOMA METASTASIS

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from 2/16, 19 49, to 2/17, 19 49, that I last saw the deceased alive on 2/17, 19 49, and that death occurred at 6:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE [signature] M. D.
23B. ADDRESS W3G Hop.
23C. DATE SIGNED 2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify) B.
24B. DATE 2/21/49
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn
24D. LOCATION (City, town, or county) (State) Eastern Cem

DATE RECEIVED BY LOCAL REGISTRAR FEB 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR James L. McCall ADDRESS 1 E. Fort Ave

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G71702

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 58

Registered No. G71702

1. NAME OF DECEASED (Type or Print): ELMER GRAVES

2. DATE OF DEATH: 16 FEB 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GEN. HOSP.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 638 W FAYETTE ST

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 21 AUGUST 1894
9. AGE (In years last birthday): 54
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PLASTERER
10B. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: JOHN GRAVES
14. MOTHER'S MAIDEN NAME: ~~[illegible]~~ Lillie CRITZER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): ~~UNKNOWN~~ Wored War I
16. SOCIAL SECURITY NO: 577-16-4401
17. INFORMANT: DECEASED ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PNEUMONIA, LEFT LOWER LUNG — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) PORTAL CIRRHOSIS — ?

DUE TO

(C) MALNUTRITION AND CHRONIC ALCOHOLISM — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: ARTERIOSCLEROTIC ~~HEART~~ DISEASE ?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6:30 AM 16 FEB, 1949, to 4 PM 16 FEB 1949, *that I last saw the deceased alive on* 16 FEB, 1949, *and that death occurred at* 4:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Donald F. England M. D.
23B. ADDRESS: MARYLAND GEN HOSP
23C. DATE SIGNED: 17 FEB 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/49
24C. NAME OF CEMETERY OR CREMATORY: Rock Gate Cem
24D. LOCATION (City, town, or county) (State): Crozet Va

DATE RECEIVED BY LOCAL REGISTRAR: FEB 19 1949
REGISTRAR'S SIGNATURE: Clarence for Williams, M.D.
25. FUNERAL DIRECTOR: Geo X Beyer Jr
ADDRESS: 1512 Hollins St

VS 150

124a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

CH. 119545
G71703

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71703

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clyde Edward Kilgore

2. DATE OF DEATH: 2- 17- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 6 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: MD.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1718 N. Calvert ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	[illegible] 27 1926	22	2 / 20	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Striper	American Can CO.	Ohio	

13. FATHER'S NAME: Peter Kilgore

14. MOTHER'S MAIDEN NAME: Ora Sivyers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Records Baltimore City Hospital ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilaterial Far Advanced Pulmonary Tuberculosis With Cavitation — INTERVAL BETWEEN ONSET AND DEATH: 5 Yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5- 8- , 1948 *to* 2 - 17- , 1949 *, that I last saw the deceased alive on* 2- 17-1949 *, and that death occurred at* 3.45 P.M. *, from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 4940 Eastern Ave.

23C. DATE SIGNED: 2-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/19/49

24C. NAME OF CEMETERY OR CREMATORY: Anderson

24D. LOCATION (City, town, or county) (State): Sunshine, Ky

DATE RECEIVED BY LOCAL REGISTRAR: FEB 19 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: William Cook Inc. ADDRESS: 1214 St Paul St

VS 150

126

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G71704

BALTIMORE CITY HEALTH DEPARTMENT 420.1

CERTIFICATE OF DEATH

G71704

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES BURRELL MARTIN

2. DATE OF DEATH: Feb. 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4318 Springwood Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 4318 Springwood Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Sept. 20, 1884	64	4 / 28	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Physician	Medical	Baltimore, Md.	

13. FATHER'S NAME: Henry Martin

14 MOTHER'S MAIDEN NAME: Cora Byrd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT ADDRESS
		Mrs Mabel Martin, 4318 Springwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CEREBRAL EMBOLISM	2 DAYS
DUE TO (B)	CORONARY ARTERY THROMBOSIS	2 DAYS
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	CORONARY ARTERIOSCLEROSIS	2 YRS (?)
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	—	—

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* FEB. 16, 1949, *to* FEB. 18, 1949, *that I last saw the deceased alive on* FEB. 17, 1949 *and that death occurred at* 12 00 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C DATE SIGNED
John W Macken M. D.	6331 Belair Rd (6)	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/21/49	Mt. Olivet	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR ADDRESS
FEB 19 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

94a

correct age is especial important. Physician: please write the cause of death clearly and legibly.

G71705

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

Registered No. G71705

1. NAME OF DECEASED (Type or Print): DOROTHY K. SMITH

2. DATE OF DEATH: February 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1013 S. Baylis Street 7 6 09

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar. 26,
9. AGE (In years last birthday): 38
If under 1 Year: Months Days
If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John C. Martin
14. MOTHER'S MAIDEN NAME: Sarah Browner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural hemorrhage

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [✓].*

23A. SIGNATURE: George G. Merrill M.D.
23B CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 2-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 21/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cem
24D. LOCATION (City, town, or county) (State): Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 19 1949
REGISTRAR'S SIGNATURE: Evelyn for Williams, M.D.
25. FUNERAL DIRECTOR: Uhl & Tyrrell Home ADDRESS: 2008 Orleans

VS 151

832a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71706

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Katherine Borgerding.

2. DATE OF DEATH: Feb. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 335 S. Ellwood Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 335 S. Ellwood Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	April 27, 1859	89	9 / 19	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home		Baltimore, Md.	

13. FATHER'S NAME: Schueler

14. MOTHER'S MAIDEN NAME: --

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No.		John A. Borgerding-Ridge & Philadelphia Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Occlusion. Acute

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Coronary Artery Atherosclerosis.

DUE TO

(C) Generalized Arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Senility.

INTERVAL BETWEEN ONSET AND DEATH: 4-5 days

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-13-49 19__ *to* 2-16-49 19__, *that I last saw the deceased alive on* 2-13-49 19__, *and that death occurred at* 10:30 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D. | 23B. ADDRESS: 642 N. Wash. Blvd | 23C. DATE SIGNED: 2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 19, 1949	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 19 1949	Huntington Williams, M.D.	Ulrich Funeral Home 2008 Orleans St.,

VS 150

94a

Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

G71707

CERTIFICATE CORRECTED 2-25-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

G71707

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ~~Mary Dressel~~ Mary Dressel

2. DATE OF DEATH 2/17/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 519 W Mt Holly St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 519 W Mt Holly St 20-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last Birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	W	Single	May 6 1895	53				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Hosiery	Balto Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Thomas Dressel	Anna Walsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Helen Dressel 519 W Mt Holly

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/16, 1949 *to* 2/17, 1949 *that I last saw the deceased alive on* 2/16, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. G. Lally M D M. D.	3517 Edmondson Ave.	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 21/49	New Cathedral, 4300 Old Frederick Rd. Balto. Md.	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Huntington Williams, M.D.	Harry R. Whitlock	4101 Edmondson Ave.

VS 150

83a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33

Registered No.

G71708

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Agnes M. Clarke

2. DATE OF DEATH 2/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1814 Wilhelm St.
c. Length of stay in Baltimore 39 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 1814 Wilhelm St. 19-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	W.	Single	Sept. 15, 1903	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
None		Maryland	

13. FATHER'S NAME Asaph Clarke

14 MOTHER'S MAIDEN NAME Sophia Drake

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO

17. INFORMANT (Sister) ADDRESS Mrs. Fannie Schaefer 1810 Wilhelm ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Thrombosis	12 hrs
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Bronchitis	2 wks
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/16/49, 19__, *to* 2/17/49, 19__, *that I last saw the deceased alive on* 2/16/49, 19__, *and that death occurred at* 5a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Walter J. Dorsey M. D.	401 Edmondson Ave	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 21/49	Mt. Olivet, 2930 Frederick Rd. Balto. Md.	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Huntington Williams, M.D.	Harry A. Leitzke	4101 EdmondsonAve

VS 150

832

Correct age is especially important. Physician: please write the cause or causes clearly and legibly.

G71709

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 191

Registered No. G71709

1. NAME OF DECEASED (Type or Print): RObert Dennis

2. DATE OF DEATH: 2/17/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1319 Madison Ave.
C. Length of stay in Baltimore: Life. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 926 N. Carrollton Ave. 16 01

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 3/22/1885
9. AGE (In years; if under 1 birthday: If under 1 Month, Days; If under 24 Hours, Hours, Min.): 63 11 22

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unmployed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Dennis
14. MOTHER'S MAIDEN NAME: Hester Weeks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Poly Dennis ADDRESS: 926 N. Carolton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of skin & metastasis to brain, & lungs — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/17, 1949, *to* 2-17-, 1949, *that I last saw the deceased alive on* 2-17-, 1949, *and that death occurred at* 1 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. M. Jackson M. D.
23B. ADDRESS: 600 N. Arlington Ave
23C. DATE SIGNED: 2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/19/1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. arburn Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1000 Brantly Ave.

VS 150

53

G71710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 442

Registered No. G71710

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROBERTA KING

2. DATE OF DEATH: Feb. 18, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3520 N. Hilton Rd.

c. Length of stay in Baltimore: Hilton Nursing Home — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3226 Gwynn Falls Pkwy.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 hours: Hours, Min.
female	white	widow	Dec. 30, 1899	49 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
teacher	Balto. City	Baltimore, Md.	

13. FATHER'S NAME: Joseph Whiteford

14. MOTHER'S MAIDEN NAME: Mary A. Susher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		no	Miss Gladys Vickers	3226 Gwynn Falls Pk wy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive Cardio vascular renal disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1946, 19__, *to* Feb 18, 1949 *that I last saw the deceased alive on* Feb 17 19 49 *and that death occurred at* 5:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Sherofsky M.D. M.D.	601 N Monroe St.	2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/21/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Hattie for Williams, M.D.	WILLIAM J. TICKNER & SONS	Balto., Md.

VS 150

131a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71711

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

416 Registered No. G71711

1. NAME OF DECEASED (Type or Print): John Morrissett

2. DATE OF DEATH: 2-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland, 6420 Reisterstown Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Institute
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 37 N. Prospect Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	white	Married	6-4-1895	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic-Westinghouse Electric		Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Charles H. Morrissett - deceased

14. MOTHER'S MAIDEN NAME: Margaret Dunlop

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	215-01-0754	The Seton Institute 6420 Reisterstown Road, Balto. 15, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pulmonary Edema	2 days.
DUE TO (B)	Agitation, myocardial insufficiency, mitral stenosis, auricular fibrillation	(information obtained from patient's wife) 30 years
DUE TO (C)	Rheumatic Ht. Disease	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	old Left Empyema & obliteration of left lower lobe of lung	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/23, 1948 *to* 2/16, 1949 *that I last saw the deceased alive on* 2/16, 1949 *and that death occurred at* 11.45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George Wanoker M. D.	Seton Institute	2/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	Loudon Park Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Huntington Williams, M.D.	WILLIAM J. TICKNER & SONS	Balto., Md.

VS 150

926

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71712

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71712

BIRTH NO.

1. NAME OF DECEASED (Type or Print): VIOLA M. DAULBAUGH (also Schussler)

2. DATE OF DEATH: February 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 506 West Fayette Street

C. Length of stay in Baltimore: Yrs. - Mos. - Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 506 West Fayette St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	divorced	July 9, 1902	46 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-	-	Cumberland, Md.	

13. FATHER'S NAME: Wm. A. Daulbaugh

14. MOTHER'S MAIDEN NAME: Sarah V. Long

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no	Mr. Frank Daulbaugh	506 W. Fayette St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myocardial degeneration	
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Chronic alcoholism	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl B. Royer M.D.		Feb. 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/21/49	Loudon Park Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Huntington for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 151

93D

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G71713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443

Registered No. G71713

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Julia Ann Spellman

2. DATE OF DEATH 2-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or Institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore Five Years (Yrs. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2413 Woodbrook

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	Negro		12-13-85	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher		Salem, N. J.	American

13. FATHER'S NAME: William Stevenson

14. MOTHER'S MAIDEN NAME: Annie M. Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Arteriosclerotic Cardiovascular Renal Disease
DUE TO
(B) Congestive Heart Failure
DUE TO
(C) Uremia

INTERVAL BETWEEN ONSET AND DEATH
(A) Years
(B) Years
(C) 2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22 *I hereby certify that I attended the deceased from* 1-3 1949 *to* 2-16 1949, *that I last saw the deceased alive on* 2-16 1949, *and that death occurred at* 3:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. E. Buckley Jr. M. D.	Provident Hospital	2-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-19-49	Spring Grove	Dundalk Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	for Williams, M.D.	Elroy O. Wilson	1000 Bentley Rd

VS 150

937

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71714

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71714

Registered No.

1. NAME OF DECEASED (Type or Print): Samuel Palmer	2. DATE OF DEATH: 2-16-49
3. PLACE OF DEATH: A. Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY: —
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
c. Length of stay in Baltimore: Life Yrs. Mos. Days	D. STREET ADDRESS (If rural, give location): 134 Jumpers Lane - Druid Village

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	Col	W	1-1-82	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Md	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jos. Palmer	—

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Bernice Parker —	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic heart	indefinite
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-11-, 1949 *to* 2-16-, 1949 *that I last saw the deceased alive on* 2-16-, 1949, *and that death occurred at* 7:00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. B. Gudel M. D.	Mercy Hospital	2-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-19-49	Mt. Auburn Cem.	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Acting for Williams, M.D.	Elroy J. Wilson	1000 Brantly ave

VS 150

937

G71715 Apl 2

BALTIMORE CITY HEALTH DEPARTMENT 356.0 G71715

CERTIFICATE OF DEATH

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): John Johnson | 2. DATE OF DEATH: FEB 18 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md | B. COUNTY: Worcester
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bishop
D STREET ADDRESS (If rural, give location): Rt. #2 Box 13

5. SEX	6. COLOR or RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored	Single	6.13.29	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
School		Delaware	

13. FATHER'S NAME: William Jones
14 MOTHER'S MAIDEN NAME: Essie Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peripheral Vascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: hours.
DUE TO
(B) Cardiac Dilatation + Dystrophy. — months.
DUE TO
(C) Progressive Muscular Dystrophy — years.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2.8. , 1949 *to* 2.18. , 1949 *that I last saw the deceased alive on* 2.18. , 1949 *and that death occurred at* 12.50 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Anthony J. Jr. M. D.	JOHNS HOPKINS HOSPITAL	2-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2-20-49	Evergreen cem	Berlin Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	[illegible] Millsboro, Md	Elroy S. Wilson	1000 Beverly ave

VS 150

95c

correct age is especially important. Physician: please write the cause of death clearly and legibly.

asl 2

G71716

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

33 ✓

Registered No. G71716

1. NAME OF DECEASED (Type or Print): Roland Smith

2. DATE OF DEATH: FEB 1 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 46 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 18 N. Dallas St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Single	1-3-84	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Wash. D.C.	

13. FATHER'S NAME: William Smith

14. MOTHER'S MAIDEN NAME: Martha ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Central Thrombosis	Some.
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Arteriosclerosis, general.	years.
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-10, 1949, *to* 2-11, 1949, *that I last saw the deceased alive on* 2-11, 1949, *and that death occurred at* 10:45 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Anthony J. Lee M. D.	JOHNS HOPKINS HOSPITAL	2-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-19-49	Mt. Calvary	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Thurston for Williams, M.D.	Eloy S. Wilson	1000 Bentley exp

VS 150

832

B.C.49-01501

G71717

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 273

Registered No. G71717

1. NAME OF DECEASED (Type or Print) NATHANIEL STOKES

2. DATE OF DEATH February 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto.Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 804 Rutland Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital Life.

C. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: I/I5/1949
9. AGE (In years last birthday) — If Under 1 Year: Months, Days: 21 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore.Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Moses Wilson
14. MOTHER'S MAIDEN NAME: Lucelle Stokes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lucelle Stokes — ADDRESS: 804 Rutland Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Upper respiratory infection — Status thymicolymphaticus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR
23C. DATE SIGNED Feb. 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 2/I9/I949
24C. NAME OF CEMETERY OR CREMATORY Mt.Calvery Cem.
24D. LOCATION (City, town, or county) (State) Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 19 1949
REGISTRAR'S SIGNATURE Evelyn Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson — ADDRESS: I000 Brantly Ave.

VS 151

64

PLEASE WRITE PLAINLY, with [illegible]. Physician: please write the cause of death clearly and legibly. Be correct age is especially important.

Yr. Cert. 2 Copies

BIRTH NO. 7718 Da Berry

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71718

1. NAME OF DECEASED (Type or Print): Annie Gunter

2. DATE OF DEATH: Feb. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 828 Harlem Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 828 Harlem Ave. 17-67

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Col.	Widowed	1880	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	Domestic	Accomack County, Va	U.S.A.

13. FATHER'S NAME: Louis White.

14. MOTHER'S MAIDEN NAME: Fannie White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Annie Gunter, ADDRESS 828 Harlem Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ch. Cardio-Renal Vascular Disease — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 1-2 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) arteriosclerosis — DUE TO — 1 yr.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm. L. Berry M. D.

23B. ADDRESS: 1420 E. Chase

23C. DATE SIGNED: 2-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb. 20, 1949

24C. NAME OF CEMETERY OR CREMATORY: Metompkin

24D. LOCATION (City, town, or county) (State): Metompkin, Va.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 19 1949

REGISTRAR'S SIGNATURE: Lucinda for Williams, M.D.

25. FUNERAL DIRECTOR: J. Edgar Thomas, ADDRESS Accomac Va

VS 150

1310

G71719

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

151

Registered No. G71719

1. NAME OF DECEASED (Type or Print): PERCY SHELTON

2. DATE OF DEATH: 2/16-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1837 N. SPRING ST.

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1837 N. Spring St 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Col	Married	1-23-1897	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Virginia	U.S.

13. FATHER'S NAME: Eli Shelton

14. MOTHER'S MAIDEN NAME: Carolina Mallory

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Mary Shelton	1837 N Spring St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Internal Hemorrhage (Intestinal) — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of Stomach - (Intestines) — 3-4 mos.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 5, 1949 *to* Feb. 16, 1949 *that I last saw the deceased alive on* Feb. 16, 1949 *and that death occurred at* 4:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. L. Berry, M. D.	1420 E. Chase St.	2-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-19-49	Mt Calvary Cem	A. A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Huntington Williams, M.D.	Payne Sanders	1412 E. Preston St

VS 150

4613

Correct age is especially important. Physicians: please write the cause of death clearly and fully.

G71720

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 911 G71720

N853-4 7

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALBERT JACQUES

2. DATE OF DEATH: February 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2820 Maisel Street 2-17-49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	1912	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	-	Maine	

13. FATHER'S NAME: Ernest J. Jacques

14. MOTHER'S MAIDEN NAME: Alma Rancourt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
yes	W. W. 2	-	Pinette Funeral Home	Lewistown Maine

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet Wound of Brain

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] ~~CAUSE OF~~ DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	2820 Maisel Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
2-17-49 1.00 p. m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	firearms

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Feb. 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/22/49	Lewistown maine	maine

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Lewis Williams, M.D.	George G. Kelson	1383 Preston 85

VS 151

6

166

Please write the cause of death clearly and legibly. Physician: Please write the cause of death clearly and legibly. Physician: Please write the cause of death clearly and legibly. Physician:

G71721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1600 Registered No. G71721

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BABY BOY LANGENFELDR
2. DATE OF DEATH: 19FEB49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GEN. HOSP
c. Length of stay in Baltimore: — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 7404 BRIGHTSIDE AVE #6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
MALE	WHITE	SINGLE	17FEB49	—	2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INFANT	—	MARYLAND	US

13. FATHER S NAME

14. MOTHER S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT
NO	NO	NONE	MRS. FREDA LANGFELDR (GRANDMOTHER) ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) INTRACRANIAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: FROM BIRTH
DUE TO
(B) BIRTH INJURY
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 18FEB, 1949 *to* 19FEB, 1949, *that I last saw the deceased alive on* 19FEB, 1949, *and that death occurred at* 2:55 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald L. England M. D.	MARYLAND GEN. HOSP	19FEB49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	Holy Redeemer Cem.	Belair Rd Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Huntington for Miriello, Mgr	Schumacher Funeral Home	1601 Madison Ave

VS 150

1600

PLEASE WRITE PLAINLY, with pencil or pen, and do not use abbreviations. Physician: please write the cause of death clearly and correct age is especially important.

G71722 ✓ G71722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 4700

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM HUMPHREYS

2. DATE OF DEATH: FEB. 18 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2014 Harford Road
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution give street address or location): 2014 Harford Road
c. Length of stay in Baltimore: 68 Yrs. 8 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2014 HARFORD ROAD 9 08

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: June 30 1880
9. AGE (In years last birthday): 68 — If Under 1 Year: Months 7 Days 18 Hours Min. — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Packer
10B. KIND OF BUSINESS OR INDUSTRY: Pickle House
11. BIRTHPLACE (State or foreign country): BALTIMORE Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Millard Humphreys
14. MOTHER'S MAIDEN NAME: Christina Brunnett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: 213-03-1434A
17. INFORMANT: Mr Millard F Humphreys ADDRESS 6809 Harford Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis
DUE TO
(B) Chronic Bronchiectasis
DUE TO
(C) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 10, 1939 *to* Feb 18, 1949, *that I last saw the deceased alive on* Feb 17 1949, *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Samuel B Wolfe M. D.
23B. ADDRESS: 1331 E Northlow
23C. DATE SIGNED: 2-18-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 21 1949
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): 3310 Taylor Ave. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: Elmer O. Conklin ADDRESS 924 E. Eager St

VS 150

924

G71723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

591

G71723

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): WLADYSLAW USTASZEWSKI (USTASIEWSKI) (DOBLIK)

2. DATE OF DEATH: February 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2038 E. Pratt Street
C. Length of stay in Baltimore: 42 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2038 E. Pratt Street 201

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: August 8,1887
9. AGE (In years last birthday): 61 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glazier
10B. KIND OF BUSINESS OR INDUSTRY: Glass
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? Poland
13. FATHER'S NAME: Ignacy Ustaszewski
14. MOTHER'S MAIDEN NAME: Maryanna -------
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: 212-10-2023
17. INFORMANT ADDRESS: Teofila Ustaszewski, 2038 E. Pratt St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2-16-21 Mos.

DUE TO

(B) Chr. Myocarditis — Jan 1 1948

DUE TO

(C) Chr. Parenchymatous Nephritis — Jan 1. 1948

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 2 1949 to Feb 17 1949, that I last saw the deceased alive on Feb 17 1949, and that death occurred at 2 30 A m., from the causes and on the date stated above.

23A. SIGNATURE: William J Pyzanek M. D.
23B. ADDRESS: 804 E Kenwood Ave
23C. DATE SIGNED: 2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/21/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or County) (State): Baltimore County

DATE RECEIVED BY LOCAL REGISTRAR: FEB 19 1949
REGISTRAR'S SIGNATURE: Courtesy for Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: M.F.Sadowski & Sons, 1808 Eastern Avenue

VS 150

131 A.

G71724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443

Registered No.

G71724

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stephan Jendrusiak (Anderson)

2. DATE OF DEATH: Feb 17 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 305 S. Cornwall St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 305 S. Cornwall St 26 0 5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	white	married	Nov 22 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor	Public School	Poland	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Annastazya Jendrusiak — ADDRESS: 305 S Cornwall St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	4 d
DUE TO (B)	Myocarditis	1 y
DUE TO (C)	Hypertension	15 y
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* Feb 17, 1949, *that I last saw the deceased alive on* Feb 17, 1949, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. J. Beelman M. D.	3426 Bank St	Feb 18 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 21/49	St. Stanislaus	Dundalk Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Huntington Williams, M.D.	John J. Duda	2129 Hudson St.

VS 150

- 6 -

93D

Please write the cause of death clearly and legibly. Physician's signature, with degree, is required. Correct age is especially important.

671725

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 49

BIRTH NO. B.C. #826902 — Registered No. 671725

1. NAME OF DECEASED (Type or Print): MARGIE L. SPRINGFIELD

2. DATE OF DEATH: February 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 304 South Franklintown Road
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 304 South Franklintown Road

20 04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	December 10, 1948		2 / 8	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore	

13. FATHER'S NAME: William F. Springfield

14. MOTHER'S MAIDEN NAME: Viola Volland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Wm. F. Springfield — ADDRESS: 304 S. Franklintown Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchopneumonia	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George L. Merrill M.D.		Feb. 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/19/49	Westview Cem.	Walkersville

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Huntington Williams, M.D.	J. B. Weybert & Son	1800 Eutaw Pl

VS 151

107 17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if correct age is especially important. Physician: please write the cause of death clearly and legibly.

BIRTH NO. 71726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 466

Registered No. 071726

1. NAME OF DECEASED (Type or Print): Grace Taylor

2. DATE OF DEATH: 2-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp
C. Length of stay in Baltimore: 26 Yrs. 7 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Md 12 - C -
D. STREET ADDRESS (If rural, give location): 408 E. Layfayette Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	C	M	11-28-1903	45	2 19	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Towson	U. S.

13. FATHER'S NAME: Joseph Matthews

14. MOTHER'S MAIDEN NAME: Maggie Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Henry Taylor ADDRESS: 408 E. Lafayette Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: Approx 15 min
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ovarian cyst — Unknown

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Feb 2, 1949 to Feb 17, 1949 that I last saw the deceased alive on Feb 17, 1949 and that death occurred at 4:00 Am., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H Garland Cridler M. D.	902 W. Franklin St	2-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2-20-49	Pleasant Rest	Towson Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 19 1949	Thurston for Williams, M.D.	Byron & Mamie Wright - Balto. Md.

VS 150

56a

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be entered correctly and completely. Correct age is especially important. Physician: please write the cause of death clearly and fully.

G71732 ✓ X G71727.

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 754 Registered No. 62

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print): Bessie Fay Williamson
2. DATE OF DEATH: 2-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Calvert & 33rd Sts
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: one — Yrs. Mos.

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: Car.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Denton
D. STREET ADDRESS (If rural, give location): R.F.D. #1 Box #1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	SINGLE	7-7-42	6	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SCHOOL CHILD	—	Maryland	America

13. FATHER'S NAME: Charles De Clyde Williamson
14. MOTHER'S MAIDEN NAME: Sylvania Mae Isaacs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	none	Father	Denton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs.
DUE TO
(B) Ear abscess — 6 weeks
DUE TO
(C) Congenital heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
0	—	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
0	0	0

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
0 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-26, 1949 *to* 2-11, 1949 *that I last saw the deceased alive on* 2-11, 1949 *and that death occurred at* — *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred Thacker M.D.	Union Memorial Hospital	2-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	Feb 15th 49	Greenwood	Greensboro, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 14 1949	Thos. E. Jessop	J. Virgil Moore & Son.	Denton

VS 150
FEB 19 1949

157E

G71728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH N 3

Registered No. G71728

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Randolph Mordecai

2. DATE OF DEATH: Feb 18 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Greenway apts Charles & 34th Sts

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 49 yrs. Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): Greenway apts Charles & 34th Sts

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	married	1870	79?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	Retired	Balto., Md	U.S.A.

13. FATHER'S NAME: J. Randolph Mordecai

14. MOTHER'S MAIDEN NAME: Emma Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Joseph Rieman McIntosh	Towson 4 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of colon & metastases to liver & lt lung — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1944	Carcinoma of Sigmoid	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/17/49, 19__, *to* 2/18/49, 19__, *that I last saw the deceased alive on* 2/12/49, 19__ *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Francis W. Gluck M. D.	3406 St Paul St	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	Feb 19 1949	Green Mount	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 19 1949	Livingston Williams, M.D.	Henry M. Jenkins Sons Co	4905 York Rd.

VS 150

46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered correctly. Use figures for dates. Be sure to give the correct age in years, months, days, hours or minutes. Physician: please write the cause of death clearly and fully. Every item is especially important.

E-9-2-5 G71729

G71729
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

N-8,9,12
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given fully. Correct age is especially important. Physician, please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): JOHN DANIELS

2. DATE OF DEATH: February 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 908 West Hollins Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	-	Unknown	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10B. KIND OF BUSINESS OR INDUSTRY: Balto Housing Authority
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: -
17. INFORMANT: Mrs Kendall ADDRESS: 908 Hollins St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A)	Fractured skull	
due to	Intracranial hemorrhage	
due to	Contusion of brain.	
due to	Fractured ribs	
due to	Ruptured right kidney	

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 251 Silver Court 5/1
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 2-18-49 approx. 9a m.
21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? Fell from scaffold when rope broke.

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR
23C. DATE SIGNED: Feb. 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2 pil 49	Mt Olivet Cem.	2930 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: FEB 19 1949
REGISTRAR'S SIGNATURE: Remains to Baltimore, Md.
25. FUNERAL DIRECTOR: John J. Cowan & Son ADDRESS: Hollins St.

VS 151

186a

ES*126308

G71730

BIRTH NO. G71730

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 593

Registered No. G71730

1. NAME OF DECEASED (Type or Print): Sanford Sperry

2. DATE OF DEATH: Feb. 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospital

c. Length of stay in Baltimore: 3 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Ky.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cattlesburg.
D. STREET ADDRESS (If rural, give location): 48 Market Place (3)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Divorced	Aug. 31, 1910	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Ky.	U.S.

13. FATHER'S NAME: Thomas R. Sperry

14. MOTHER'S MAIDEN NAME: Mary Morris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS: RECORDS*BALTO. CITY HOSPITALS Eastern Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema

DUE TO

(B) Pulmonary Abscess

DUE TO

(C) Fatty Metamorphosis of liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Toxic Nephrosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-23 19 49 *to* Feb. 18 19 49, *that I last saw the deceased alive on* Feb. 18 1949, *and that death occurred at* 10:55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. L. Rogers M. D.	4940 Eastern Avenue	2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
REMOVAL	FEB 19 1949	CATLETTSBURG	CATLETTSBURG KENTUCKY

DATE RECEIVED BY LOCAL REGISTRAR: FEB 20 1949

REGISTRAR'S SIGNATURE: Williams, MD

25. FUNERAL DIRECTOR: Wm Cook Inc ADDRESS: 1217 St Paul St.

VS 150

Rewritten for Williams, M.D.

124 R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. If any cannot be ascertained, state so. Do not use abbreviations. The correct age is especially important. Physicians, please write the cause of death clearly and legibly.

190063
G71731

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 59

G71731 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be complete, accurate and legible. Cemetery supplies correct age is especially important. Physician: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print): Morris J Lipkovitz

2. DATE OF DEATH: FEB 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: N.J.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Trenton
D. STREET ADDRESS (If rural, give location): 732 Edgewood Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 3-25-02
9. AGE (In years last birthday): 46 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Live Stockbuyer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel Lipkovitz
14. MOTHER'S MAIDEN NAME: Rebecca Doneshefsky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic glomerulonephritis — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-3- *,* 1949 *to* 2-19 *,* 1949 *that I last saw the deceased alive on* 2-19- *,* 1949 *, and that death occurred at* 6 35 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. S. Wilner M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 20, 1949
24C. NAME OF CEMETERY OR CREMATORY: Greenwood Cemet. Trenton N. J.
24D. LOCATION (City, town, or county) (State): Trenton N. J.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 20 1949
REGISTRAR'S SIGNATURE: Courtney for Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 150

1213

G71732 X G71732

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anthony Mary

2. DATE OF DEATH: February 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore FRED'K
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): Md. State Sanatorium

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	9-13-83	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Phillip Mary

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pulmonary Tuberculosis	2 yrs +
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Carcinoma of Bladder	2 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
Jan 49	Bladder Carcinoma	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-17 1949 *to* 2-19 1949, *that I last saw the deceased alive on* 2-19 1949, *and that death occurred at* 4 35 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul H Bunce M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Feb. 19, 1949	Prospect Hill	Washington, D.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 20 1949	[illegible]	Wm. J. Tickner & Sons North & Pa. aves.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

52 B

G71733 ✓ G71733

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4/20 1

Registered No.

1. NAME OF DECEASED (Type or Print): MRS. MEYER (EDA) CAPLAN

2. DATE OF DEATH: 2-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. 62 yrs, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3512 Reisterstown Road 15 1/2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	White		(unknown) 1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Russia	USA

13. FATHER'S NAME: Isaac Goldstein

14. MOTHER'S MAIDEN NAME: Mary Goldstein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT: Pfc. Adm. Meyer Caplan ADDRESS: 3512 Reisterstown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Feb 18, 1949, *to* Feb 20, 1949, *that I last saw the deceased alive on* Feb 19, 1949, *and that death occurred at* 3:20 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. P. Benson, Jr. M. D.	Union Memorial Hosp.	2-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 21, 1949	Hebrew Washington Rd Cem	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 20 1949	Washington Williams, M.D.	Sol Levinson & Bros	1126 W North Ave

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

94a

G71734 ✓ G71734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): BESSIE SACHS

2. DATE OF DEATH: Feb. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 17 E. Cross Street
c. Length of stay in Baltimore: 50 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 17 E. Cross Street 23-02

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 1871
9. AGE (In years last birthday): 78 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Solomon Z. Segall
14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Irvin Sachs — ADDRESS: 17 E. Cross St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ch Myocardial failure
DUE TO
(B) Ch Hypertension
DUE TO
(C) Ch arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/13, 1949 *to* 2/17, 1949 *that I last saw the deceased alive on* 2/17, 1949, *and that death occurred at* 1 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. L. Hornstein, M. D.
23B. ADDRESS: 207 E. Biddle St
23C. DATE SIGNED: 2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/49
24C. NAME OF CEMETERY OR CREMATORY: Anshei Emunah Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: 2/19/49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol. Levinson Bros. ADDRESS: 1124-26 W. North AV.

VS 150

937

G71735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 483

G71735

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Eugenio Lorenzi

2. DATE OF DEATH: Feb.17 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 521 S. Ponca St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
521 S. Ponca St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore Md.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Aug.18 1899	49	5 / 29	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bricklayer		Limana Belluno Italy	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Giovanni Lorenzi	Maddalena ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	086-10-5046	Antonia Flatcher	521 S.Ponca St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Influenzal Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 9 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Influenza — 11 days

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-7-49, 19__, *to* 2-17-49, 19__, *that I last saw the deceased alive on* 2-16-49, 19__, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Costantino M. D.	234 S. Conkling St	2-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb.21st/49	Holy Redeemer Cem.	Belair Rd.Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 20 1949	for Williams, M. D.	Frank Della Rose	322 S. High st.

VS-180

6

33R

G71736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 151

Registered No. G71736

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Lucia Bonvegna

2. DATE OF DEATH Feb. 18 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3511 Gough St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 38 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
3511 Gough St. 76 C 8
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore Md.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	May 12 1883	65	9 / 6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Forza D'Agro' Italy	

13. FATHER'S NAME: Angelo Di Cara

14. MOTHER'S MAIDEN NAME: Caterina Lombardo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — ADDRESS: Salvatore Bonvegna 3511 Gough St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized carcinomatosis — Interval between onset and death: 4½ mo.

DUE TO

(B) Adenocarcinoma, stomach — 11

DUE TO

(C) Metastatic CA, liver, etc. — "

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Oct. 1948	Generalized carcinomatosis, stomach, liver, etc.	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 27 Nov., 1948, *to* 18 Feb., 1949, *that I last saw the deceased alive on* 18 Feb., 1949, *and that death occurred at* 2.25 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph Drozd M. D.	2601 Eastern Ave.	19 Feb. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 21st/49	Holy Redeemer Cemtery	Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Lucy Washington, M.D.	Frank Della Rocca	322 S. High St.

46 R

G71737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153 Registered No. G71737

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Charles Rocco Rabai

2 DATE OF DEATH Feb. 16 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2715 Beechland Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE
B COUNTY
2715 Beechland Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore md.
D STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	August 16 1885	63	6	2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Retired		Pavia Italy	

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Francesco Rabai	Angela Cattaneo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Louis Rabai	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I (A) Carcinoma of Sigmoid — INTERVAL BETWEEN ONSET AND DEATH: April 1948

DUE TO

(B) Chronic myocarditis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
April 1948	Carcinoma of sigmoid	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 25, 1949 *to* Feb. 18, 1949 *that I last saw the deceased alive on* Feb 18, 1949 *and that death occurred at* 1.30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E J ALESSI M. D.	6217 Harford Road	2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City), town, or county) (State)
Burial	Feb. 21st/49	New Cathedral Cem.	Old Frederick Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 20 1949	Thurlington for Baltimore, Md.	Arault Della Rocca	322 S. High St.

VS 150

46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

40 1.5 Registered No. 71738

BIRTH NO. 71738

1. NAME OF DECEASED (Type or Print) Santo Navarria

2. DATE OF DEATH Feb. 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4805 Calumet Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 16 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 4805 Calumet Ave
B. COUNTY 76 CT
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Sept. 16 1890	58	5 / 3	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tile Work		Catania Italy	U.S.

13. FATHER'S NAME: Ascenzio Navarria

14. MOTHER'S MAIDEN NAME: Agnes Longo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1 World War		Josephine Navarria	4805 Calumet Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ch Myocarditis.

DUE TO

(B) Ac Rheumatic Fever

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Ch Hypertension.

INTERVAL BETWEEN ONSET AND DEATH: 10 mo.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1948, *to* Febr. 19, 1949, *that I last saw the deceased alive on* Febr 18, 1949, *and that death occurred at* 5 30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. S. Hardesty M. D.	3805 Belair Rd	2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 22 1949	Holy Redeemer Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 20 1949	Washington Williams, M.D.	Grant Dillon	32 S. High St.

VS 150

937

G71739 ✓ 71739 9

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 5810 Registered No.

1. NAME OF DECEASED (Type or Print): John E. Norris

2. DATE OF DEATH: 2-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Life 74 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balti: more
D. STREET ADDRESS (If rural, give location): 2722 N. Calvert St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	W	------	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (State or foreign country): Balto.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Norris
14. MOTHER'S MAIDEN NAME: Charlotte E. Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia, Anemia, + Hypoprotenemia
DUE TO
(B) Massive Gastro-Intestinal Hemorrhage
DUE TO
(C) Liver Cirhosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-5- 1949 to 2-19- 1949, *that I last saw the deceased alive on* 2-19 1949, *and that death occurred at* 9:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE C. D. Thomas, Jr. M. D.
23B. ADDRESS Mercy Hosp.
23C. DATE SIGNED 2-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/22/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: H. A. Mears & Son 805 N. Calvert St.

VS 150

124 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71740 ✓ G71740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59 ✓

Registered No. 3698

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print): JOANNA VICTORIA STEPNEY

2. DATE OF DEATH: Feb. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1500 N. Fanrale St.
C. Length of stay in Baltimore: 59 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 1500 N. Fanrale St.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12/12/1889
9. AGE (In years last birthday): 59 — If Under 1 Year: Months / Days 4 — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Joseph John Ferell
14. MOTHER'S MAIDEN NAME: Harriett ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: James H. Stepney ADDRESS: 1500 N. Fanrale St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chr. Nephritis — INTERVAL BETWEEN ONSET AND DEATH: over two years
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Hypertension — Unknown

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-20-, 1949, *to* 2-16-, 1949, *that I last saw the deceased alive on* 2-16-, 1949, *and that death occurred at* 1 P m, *from the causes and on the date stated above.*

23A. SIGNATURE: Frank A. Saunders M. D.
23B. ADDRESS: 1029 N. Stricker St
23C. DATE SIGNED: 2-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Plc.
24D. LOCATION (City, town, or county) (State): Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jos. George H. Holland - David Hill Co.
ADDRESS: 3/

VS (50) FEB 20 1949

121a

G717:1 ✓ X G717:1

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Yr. 1 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Leroy C. DeFrank

2. DATE OF DEATH: 17 Feb. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital (D.O.A.)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 8022 Old Philadelphia Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	Oct-8-1905	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Steel Worker	Bethlehem Steel	New Port News, Va.	

13. FATHER'S NAME: Byrd DeFrank
14. MOTHER'S MAIDEN NAME: Agnes ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 213-07-6994
17. INFORMANT: Mrs. Sophia DeFrank ADDRESS 8022 old Phila

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Artery Disease	
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C DATE SIGNED
Wm. H. Kammer, Jr. M.D.	☐	18 Feb. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/21/49	Holy Redeemer	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 20 1949	[illegible]	Leonard J. Luck	5305 Harford

VS 151

94a

Dr. Grott 71742 71742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 450.0

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print): Josephine Link

2. DATE OF DEATH: Feb. 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2830 Fleetwood Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2830 Fleetwood Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	June 20, 1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Henry Bruns

14. MOTHER'S MAIDEN NAME: Magdelene Kieffner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT ADDRESS: Mrs. Bessie Pflefer, 2830 Fleetwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) generalized arterio-sclerosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Decubitus ulcer. — 1 mo.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 20 1949 *to* Feb. 18 1949, *that I last saw the deceased alive on* Feb 16 1949 *and that death occurred at* 7 00 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Harold A. Grott M. D.

23B. ADDRESS: 8102 Harford rd

23C. DATE SIGNED: 2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-21-49	Parkwood Cem	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: FEB 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road.

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Dr. Mc Grath G71743
1 E. Randall

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450.0

Registered No. G71743

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print)	Philip J. Hoenig
2. DATE OF DEATH	Feb. 17, 1949
3. PLACE OF DEATH: A.	Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	3139 Northway Drive
c. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	3139 Northway Drive
5. SEX	male
6. COLOR OR RACE	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	married
8. DATE OF BIRTH	Sept. 18, 1878
9. AGE (In years last birthday)	70
If Under 1 Year: Months / Days	
If Under 24 Hours: Hours / Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	retired
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Stephen Hoenig
14. MOTHER'S MAIDEN NAME	Sophia Geiling
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO	
17. INFORMANT ADDRESS	Mrs. Catherine Hoenig, 3139 Northwy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerosis (arteriosclerosis)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1948 *to* Feb 17, 1949 *that I last saw the deceased alive on* Feb 17, 1949 *and that death occurred at* 11:0 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Denis J. Mc Grath M. D.	1 E. Randall St. 30.	2-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-21-49	Holy Redeemer Cem	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 20 1949	Huntington Williams M.D.	Leonard J. Ruck, 5305 Harford Rd.

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Dr. English
5713 Belair

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 71744

BIRTH NO. G71744

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print)	Nellie Louise Bruening
2. DATE OF DEATH	Feb. 17, 1949
3. PLACE OF DEATH: A.	Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	3707 Ridgecroft Road
c. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	3707 Ridgecroft Road
5. SEX	female
6. COLOR OR RACE	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	widowed
8. DATE OF BIRTH	Jan. 21, 1881
9. AGE (In years last birthday)	68
If Under 1 Year: Months / Days	
If Under 24 Hours: Hours / Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	at home
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Charles F. Lutz
14. MOTHER'S MAIDEN NAME	Frederica Blaich
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO	
17. INFORMANT ADDRESS	Mr. John Bruening, 2727 Inglewood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Arteriosclerotic Heart Disease — many years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1947, *to* Feb 17, 1949, *that I last saw the deceased alive on* Feb 17, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	Max R. English M. D.	23B. ADDRESS: 5713 Belair Rd
23C. DATE SIGNED	2-18-49.	
24A. BURIAL, CREMATION, REMOVAL (Specify)	Burial	24B. DATE: 2-21-49
24C. NAME OF CEMETERY OR CREMATORY	St. Matthew's	24D. LOCATION (City, town, or county) (State): Baltimore, Md.
DATE RECEIVED BY LOCAL REGISTRAR	FEB 20 1949	REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR ADDRESS	Leonard J. Ruck, 5305 Harford Road.	

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49

G71745

BIRTH NO. G71745 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): SARAH RHODY

2. DATE OF DEATH: 2-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levendale

C. Length of stay in Baltimore: 28 Yrs. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2109 Eagle St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years. If under 1 year, Months, Days. If under 24 hours, Hours, Min.): 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Hyman Wolf
14. MOTHER'S MAIDEN NAME: Sarah
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Jack C Rhody ADDRESS: 2100 Burleith Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Virus pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Myocardial fibrosis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-28, 1948 to 2-20, 1949 that I last saw the deceased alive on 2-20, 1949, and that death occurred at 5a m., from the causes and on the date stated above.

23A. SIGNATURE: Henry Nagel M.D.
23B. ADDRESS: Levendale Home
23C. DATE SIGNED: 2-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-20-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 20 1949
REGISTRAR'S SIGNATURE: Dorothy Lee Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

93D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1949

BIRTH NO. G21746 Registered No. G21746

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. Be correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print): ROSE VERNAGO

2. DATE OF DEATH: FEB. 18-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1533 HOLBROOK. ST.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

c. Length of stay in Baltimore: 40 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1533 HOLBROOK. ST.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE MD.
D. STREET ADDRESS (If rural, give location): 1533 Holbrook Street 9 c 9

5. SEX: FEMALE
6. COLOR OR RACE: WHITE.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: FEB. 8-1898
9. AGE (In years last birthday): 51 (If under 1 year: Months 0, Days 10; If under 24 hours: Hours V, Min. J)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE

11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? CONRAD.
14. MOTHER'S MAIDEN NAME: Dont. Know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: ?
17. INFORMANT: Mrs. Clara Murphy. ADDRESS: 1213 E Fa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Abdominal
DUE TO
(B) & Pelvic Cancer
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Feb 1948
19B. MAJOR FINDINGS OF OPERATION: Carcinoma
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Nov 25, 1948 *to* Feb 18, 1949 *that I last saw the deceased alive on* Feb 18, 1949, *and that death occurred at* 5P m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. E Church M. D.
23B. ADDRESS: 11 E Chase
23C. DATE SIGNED: 2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-22-49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Park
24D. LOCATION (City, town, or county) (State): Taylor Ave, Balto Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 20 1949
REGISTRAR'S SIGNATURE: Pauline V. Williams, M.D.
25. FUNERAL DIRECTOR: George J. Ruth Inc
ADDRESS: 1735 Hartford Ave

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print) George Conrad Boettger	2. DATE OF DEATH February-18-1949
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at his home	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
c. Length of stay in Baltimore Life (Yrs. Mos. Days)	D. STREET ADDRESS (If rural, give location) 2315 Arunah Avenue
5. SEX Male	6. COLOR or RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec-24-1883
9. AGE (In years last birthday) 65 years (If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY Dry Goods
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Conrad Boettger	14. MOTHER'S MAIDEN NAME Elizabeth Zinkhan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO 212-01-7596
	17. INFORMANT Mrs. Gertrude M. Boettger(wife) ADDRESS Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Arteriosclerosis — ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar 1, 1944, *to* Feb 18, 1949, *that I last saw the deceased alive on* Feb 18, 1949, *and that death occurred at* 1130A m., *from the causes and on the date stated above.*

23A. SIGNATURE Carl P. Rosario M. D.	23B. ADDRESS 1314 W Lombard St	23C. DATE SIGNED 2/18/49
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb-21-1949	24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE Hunting for Williams, M	25 FUNERAL DIRECTOR ADDRESS Jos. Joerdens & Son, 1927 Park Avenue, Baltimore, Maryland.

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G71748 — BALTIMORE CITY HEALTH DEPARTMENT — G71748

BIRTH NO. G71748

CERTIFICATE OF DEATH

Registered No. N-1554

1. NAME OF DECEASED (Type or Print): ANNA RUTH WATSON

2. DATE OF DEATH: February 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 7700 Wilson Avenue 27-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	divorced	April 19, 1910	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
clerk	Sterling Shoe Store	New York State	

13. FATHER'S NAME: Joseph O. Bennett

14. MOTHER'S MAIDEN NAME: Viola Hallaway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
-		-

17. INFORMANT: Mr. Floyd K. Watson ADDRESS: 1600 E. Cold Spring Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet-wound of brain.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	7700 Wilson Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
2-18-49 ?p. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Firearms

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		Feb. 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/21/49	-	Salisbury, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 20 1949	Pauline for Williams M.D.	WM. J. TICKNER & SONS	Balto., Md.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 4-20-d

Registered No. G-21749

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Rebecca L. McCrobie

2. DATE OF DEATH: Feb. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harford Nursing Home, 4700 Harford Rd.
c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): 32 Eastchip Road

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W.
8. DATE OF BIRTH: Aug. 14, 1870
9. AGE (In years last birthday): 78 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oakland, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Hampton McCrobie
14. MOTHER'S MAIDEN NAME: Margaret —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Rosie E. McCrobie, ADDRESS: 819 Linden Ave., York, Pa.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary occlusion	24 hrs
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Arterio sclerotic Cardio Vascular Disease	3 yrs.
	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November, 1945 *to* 18-Feb, 1949, *that I last saw the deceased alive on* 18-Feb, 1949 *and that death occurred at* 2.45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Chas W. McEdwards M. D.
23B. ADDRESS: 2746 Via Alameda
23C. DATE SIGNED: 19-Feb-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 21 1949
24C. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
24D. LOCATION (City, town, or county) (State): Oakland, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 20 1949
REGISTRAR'S SIGNATURE: Emerson for Williams, M.D.
25. FUNERAL DIRECTOR: Roland L. Fisher, ADDRESS: 2112 Dundalk Ave.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4 no. 1

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Marion V. Fischer
2. DATE OF DEATH: 18 Feb. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1235 Gusryan St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2901 OVERLAND AVE 2-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	WIDOWED	DEC 6 1883	65	2	13

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
AT HOME.		BALTIMORE	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JAMES KEYS	MARY E SULLINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	NONE.	DR HARRY KANE	1501 NORTHWICK RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Thrombosis	1/2 hr.
DUE TO		
(B)	Hypertensive Cardio-Vascular Disease	2 yrs.
DUE TO		
(C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Wm. H. Kammer, Jr. M.D.	☑	20 Feb. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
BURIAL	FEB 21 1949	NEW CATHEDRAL	OLD FREDERICK RD	MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 20 1949	Huntington Williams, M.D.	Diffpel Bro.	1800 E LOMBARD ST

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 420

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SOPHIA BAKER

2. DATE OF DEATH: FEB. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3808 Pinewood Avenue
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3808 Pinewood Avenue 27 05

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Nov. 23, 1881
9. AGE (In years last birthday): 67 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Louis Brandt
14. MOTHER'S MAIDEN NAME: Sophia Themyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Minerva Gransee- ADDRESS: 53 Wise Ave Dundalk

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) MYOCARDIAL DEGENERATION	2 YRS.
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C) ARTERIOSCLEROTIC HEART DISEASE	10 YRS.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CHRONIC ARTHRITIS (DEFORMANS) BRONCHO-PNEUMONIA (TERMINAL)	2 DAYS

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JAN. 15, 1949 *to* FEB. 17, 1949 *that I last saw the deceased alive on* FEB. 17, 1949 *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: John M. Macken M. D.
23B. ADDRESS: 6331 Belair Rd (6)
23C. DATE SIGNED: 2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 2/21/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Huntington for Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

BALTIMORE -13, MARYLAND 93c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

FEB 20 1949

CERTIFICATE CORRECTED 2-23-49.

G717:52 BALTIMORE CITY HEALTH DEPARTMENT G717:52

CERTIFICATE OF DEATH

5 76 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) OTTILLIE M. LAIRD

2. DATE OF DEATH February 18, 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3823 Beech Avenue

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 3823 Beech Avenue 13-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Married	June 21, ~~1895~~	~~52~~ 53				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Anthony Skirvan	Frances

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	none	Warren Wm. Laird- 3823 Beech Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchiectasis — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs.

DUE TO

(B) Pneumonia - 20 yrs ago

DUE TO

(C) Emphysema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
NO	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 1/29, 1949, *to* 2/18, 1949, *that I last saw the deceased alive on* 2/16, 1949 *and that death occurred at* 8 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William J. Jenner M. D.	11 W. 29th St.	2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/21/49	Parkwood Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 20 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND 116 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and forcibly.

AB-126387

BIRTH NO. G717:3

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G717:3 Registered No.

1. NAME OF DECEASED (Type or Print): Johanna Dorman

2. DATE OF DEATH: Feb. 18-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1235 Gusryan Street

5. SEX: M
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan. 25- 1865
9. AGE (In years last birthday) / If under 1 Year: Months Days / If under 24 Hours: Hours Min.: 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: William Sullins-or-Sullens (Dec.)
14. MOTHER'S MAIDEN NAME: Johanna Hubbard (Dec.)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Baltimore City Hospitals Records- 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Coronary Thrombosis	2 hrs.
	DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	Arteriosclerotic Heart Disease	?
	DUE TO		
	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT			

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 26- , 1949 *to* Feb. 18- , 1949, *that I last saw the deceased alive on* Feb. 18- , 1949, *and that death occurred at* 9.55A m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Logan M. D.
23B. ADDRESS: Balto City Hosp.
23C. DATE SIGNED: -6-0

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/22/49
24C. NAME OF CEMETERY OR CREMATORY: Mount Carmel
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC. ADDRESS: BALTIMORE - 13, MARYLAND 93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and forcibly.

MARGIN RESERVED FOR BINDING

G71754

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71754

BIRTH NO. | Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print): LOUISE STECKER

2. DATE OF DEATH: Feb. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Southern Hospital & Home, 2510 Greenmount Avenue
c. Length of stay in Baltimore: Yrs. Life, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1729 Terrell Place

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Feb. 25, 1872
9. AGE (In years last birthday): 76 | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Stecker
14. MOTHER'S MAIDEN NAME: Magdalene Gaul

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mrs. Margaret Leicht- ADDRESS: 1739 N. Carolin Stree

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Insufficiency
DUE TO
(B) Coronary Thrombosis
DUE TO
(C) Arteriosclerotic Hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 16, 19 49 *to* Feb. 18, 19 49 *that I last saw the deceased alive on* Feb. 18, 19 49 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: K. Trangott M. D.
23B. ADDRESS: 1623 E. Monument
23C. DATE SIGNED: 2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/21/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: FEB 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: NORTH AVE. & BROADWAY

94a

G717:5 ✓ X E919.8 G717:5

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): William Flory — N-803 ✓ — 2. DATE OF DEATH: 20 Feb. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital (DOA)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Waynesboro
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Single		18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student		Pa.	

13. FATHER'S NAME: Lester Flory
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gunshot wound of head (22 Cal.) — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Field	Chimney Rock Mountain, Pa.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑	21F. HOW DID INJURY OCCUR?
Feb 20, 1949 5 P. m.		While target shooting.

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Wm. H. Kammer, Jr. M.D.		20 Feb. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Removal	2/23/49	Waynesboro, Pa.	Waynesboro, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
FEB 21 1949	Huntington Williams, M.D.	W. J. Tickner & Sons, North & Penna Ave. 184

VS 151

G717:56 G717:56

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

760 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby Boy Hoxter

2. DATE OF DEATH: February 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md. B. COUNTY: Caroline
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Goldsboro
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Colored	child	2-11-49		9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Hoxter
14. MOTHER'S MAIDEN NAME: Viola Black

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ✓
(If yes, give war or dates of service): ✓
16. SOCIAL SECURITY NO: ✓
17. INFORMANT: JOHNS HOPKINS HOS. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) prematurity

DUE TO

(B) jaundice – ? aspiration pneumonia

DUE TO

(C) ? intra cranial hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-11, 1949 *to* 2-20, 1949 *that I last saw the deceased alive on* 2-20, 1949, *and that death occurred at* 5^17 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. O. Pearson M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/21/49
24C. NAME OF CEMETERY OR CREMATORY: Union
24D. LOCATION (City, town, or county) (State): Near Goldsboro, Md.

DATE RECEIVED BY REGISTRAR: FEB 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. E. Boulais ADDRESS: Greensboro, Md.

FEB 2nd 1949

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G717.7 71-126914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G717.7

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George W. Garner

2. DATE OF DEATH: Feb. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 75 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1804 Jackson St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 7, 1868
9. AGE (In years last birthday): 80 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George W. Garner
14. MOTHER'S MAIDEN NAME: Mary ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Balto. C. H. Records, ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 9 yrs.
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [Yes] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 15, 1949, *to* Feb. 19, 1949, *that I last saw the deceased alive on* Feb. 19, 1949, *and that death occurred at* 8.15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 2-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/22/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county): Waldorf (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilkerson & Son
ADDRESS: 1214 Druid Park Dr.

VS 150

13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Physician's please write the cause of death clearly and legibly. Correct age is especially important.

6717:58 AV 72611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 491

6717:58 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physician please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): John Kelly SR.

2. DATE OF DEATH: 2- 20- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 6 Years (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 513 N. Decker Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	W	Nov. 13 1858	90		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	

13. FATHER'S NAME: Peter Kelly

14. MOTHER'S MAIDEN NAME: Ann Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records Balto. City Hospitals	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Broncho-pneumonia	4 Days
	DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)		
	DUE TO		
	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Cerebral Vascular Accident	1 week

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 3 - 12- , 1942, *to* 2- 20- , 1949, *that I last saw the deceased alive on* 2 -20- 1949, *and that death occurred at* 4.30 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. L. Rogers M. D.	B.C.H. 4940 Eastern Ave	2- 20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/22/49	Mt. Olivet Cemetery	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, M.D.	Wilson Cook Inc	1219 E. Pratt St

VS 150

832

6717:59 BALTIMORE CITY HEALTH DEPARTMENT 491 6717:59

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C. # 25215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Daphne Krause

2. DATE OF DEATH: Feb. 20 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 3- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 636 N. Washington St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): —
8. DATE OF BIRTH: Nov. 18- 1948
9. AGE (In years last birthday): If Under 1 Year — Months: 3, Days: 2; If Under 24 Hours — Hours: , Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lewis A. Krause
14. MOTHER'S MAIDEN NAME: Lizzie Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchiolitis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 19 '49 to Feb 20, 1949 *that I last saw the deceased alive on* Feb. 20 1949 *and that death occurred at* 9 — a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Eugene Goldstein M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 2/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): removal
24B. DATE: 2/21/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Howell - Michigan

DATE RECEIVED BY LOCAL REGISTRAR: FEB 21 1949
REGISTRAR'S SIGNATURE: Huntington for Williams, M.D.
25. FUNERAL DIRECTOR: Philip Herwig Sons ADDRESS: 2024 Orleans St.

VS 150

107

G71760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44

Registered No. G71760

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Emma Marie Isaac, Tides Holland

2. DATE OF DEATH: February 17 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore City Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 806 N. Bond St.
C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission):
A STATE
B COUNTY
806 N. Bond St
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D STREET ADDRESS (If rural, give location): 806 N. Bond ST

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan 3, 1899
9. AGE (In years last birthday): 50 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Isaac
14. MOTHER'S MAIDEN NAME: Ida Bryant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Sylvester Holland ADDRESS: 806 N Bond St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(B) hypertensive cardio-renal disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS. IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/10, 1949 to 2-17, 1949 that I last saw the deceased alive on 2-16, 1949, and that death occurred at 4·27 a.m. p.m., from the causes and on the date stated above.

23A. SIGNATURE: [signature] RAYNER BROWNE, M.D.
ADDRESS: 1500 EAST MADISON ST. Baltimore, MD.
23C DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 21/49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Park
24D LOCATION (City, town, or county) (State): Arbutus Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams MD
25 FUNERAL DIRECTOR: Mrs Rob A. Elliott or Draughty
ADDRESS: 1129 N. Carlton St

VS 150

1314

G71701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 1

Registered No. G71701

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Randolph Nelson Dame

2. DATE OF DEATH: February 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1314 Bolton St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1314 Bolton St. 11 0 4

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 18, 1880
9. AGE (In years last birthday): 68 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real estate
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William M. Dame
14. MOTHER'S MAIDEN NAME: Susan N. Funsten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: William Page Dame, Jr. ADDRESS: Ruxton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

DUE TO

(B) Arterio-sclerosis — Gradual

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June, 1942 *to* Feb 19, 1949 *that I last saw the deceased alive on* Feb 19, 1949 *and that death occurred at* 1 04 m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. M. Moody M. D.
23B. ADDRESS: 1403 Park Avenue
23C. DATE SIGNED: Feb 21 '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/21/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 21 1949
REGISTRAR'S SIGNATURE: Deputy for Williams, M.D.
25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Pl.
Wm O Mitchell

VS 150

94a

G71762

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 19 48

G71762

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) MRS. CARRIE BACON SCOTT

2. DATE OF DEATH FEB. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 18
D. STREET ADDRESS (If rural, give location) 4018 DEEPWOOD ROAD

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED
8. DATE OF BIRTH JULY 6, 1866
9. AGE (In years last birthday) 82 — If Under 1 Year: Months 7, Days 13 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME JOHN BACON
14. MOTHER'S MAIDEN NAME PAMELIA LYDIA COLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT MRS. ELIZABETH KIRK ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lymphosarcoma, metastatic — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JAN. 23, 1949, *to* FEB. 19, 1949, *that I last saw the deceased alive on* FEB. 19, 1949, *and that death occurred at* 1.05 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Glenn P. Grove M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 2-22-49
24C. NAME OF CEMETERY OR CREMATORY Gunpowder Meeting House - Friends Cem'ty
24D. LOCATION (City, town, or county) Sparks (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 21 1949
REGISTRAR'S SIGNATURE Hunting for Williams, M.D.
25. FUNERAL DIRECTOR John O. Mitchell & Sons, Inc. ADDRESS 1900 Eutaw Place
Mahlon B. Mitchell

VS 150

555

G71763

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48

Registered No. G71763

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician, please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): ROBERT TIBBS

2. DATE OF DEATH: February 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: 30-40 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 437 Henrietta Avenue 7-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	Widowed	1896	52	—	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Railroad	Va	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Eleanore Boone	437 W. Henrietta St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of throat
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		Feb. 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-25-49	Mt. Auburn	Balto.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, M.D.	James Stango	142 W. Hudson St

VS 151

45F

✓ 420.0

G71764

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45

G71764

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) MR. GEORGE VOLENICK

2. DATE OF DEATH 2/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md (7) B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 4501 Springdale Ave 28 0 W

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER | 8. DATE OF BIRTH 2-5-1874 | AGE (In years last birthday) 75 | If Under 1 Year: Months 15, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MASTER MECHANIC

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) GERMANY

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME UNKNOWN

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT DR. LEE J. VOLENICK ADDRESS 4501 Springdale

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease ?

DUE TO

(C) Generalized arteriosclerosis ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Early gangrene of great toe 1 week

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/18 19 49, *to* 2/20 19 49, *that I last saw the deceased alive on* 2/20 19 49, *and that death occurred at* 8.00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE William J. Womack M.D. | 23B. ADDRESS BON SECOURS HOSP. | 23C. DATE SIGNED 2/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Feb 22-49. | 24C. NAME OF CEMETERY OR CREMATORY WOODLAWN | 24D. LOCATION (City, town, or county) (State) WOODLAWN CEM.

DATE RECEIVED BY LOCAL REGISTRAR FEB 21 1949 VS 150 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25 FUNERAL DIRECTOR Ellsworth Womack | ADDRESS 3911 Liberty Heights Ave 931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physician: please write the cause of death clearly and forcibly.

G71765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450.0

G71765

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Ernest A. Ehlis

2. DATE OF DEATH 2-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4113 Penhurst Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore 28Years (Yrs. Mos. Days)

5. SEX: Male
6. COLOR or RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: 1-26-1865
9. AGE (In years last birthday): 84 (If under 1 year: Months / Days: 24 / If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Marketer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: August Ehlis
14. MOTHER'S MAIDEN NAME: Louise Himmeringhaus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. H.W. Taylor ADDRESS: 4113 Penhurst Ave.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* July 17, 1946 *to* Feb 17, 1949 *that I last saw the deceased alive on* Feb 17, 1949, *and that death occurred at* 1015A *m., from the causes and on the date stated above.*

23A. SIGNATURE Carl P. Rostkis M. D.
23B. ADDRESS 4413 Penhurst Ave
23C. DATE SIGNED Feb 21. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-22-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ellsworth Remacost ADDRESS: 3911 Liberty Heights Ave.

VS 150

97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician, please write the cause of death clearly and legibly.

G71766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1949

Registered No. G71766

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JACOB WOLFSHEIMER.

2. DATE OF DEATH 2/20/1949.

3. PLACE OF DEATH
A. Baltimore City, Maryland Alhambra Apts.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 78 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write R.F.D. and give township) Baltimore
D. STREET ADDRESS (If rural, give location) Alhambra Apts. 13-1

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 10/17/1870
9. AGE (In years last birthday) 78 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Clothing Merchant.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF (What country) U.S.A.

13. FATHER'S NAME Nathan Wolfsheimer
14. MOTHER'S MAIDEN NAME Babette Schoolherr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Mr. Archie T. Wolfsheimer, ADDRESS 3608 Springdale Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Arteriosclerosis,
DUE TO
(B) Cardiac Insufficiency,

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH
(A) ?
(B)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1944 *to* Feb 20, 1947, *that I last saw the deceased alive on* Feb 20, 1949, *and that death occurred at* 1 45 *pm., from the causes and on the date stated above.*

23A. SIGNATURE Samuel Ephrim, M.D.
23B. ADDRESS 1261 E. North Ave.
23C. DATE SIGNED 2/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 2/21/1949.
24C. NAME OF CEMETERY OR CREMATORY Hebrew Friendship
24D. LOCATION (City, town or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 21 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR David Sonnheim & Son.
ADDRESS 1902 Eutaw Place.

VS 150

95=

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and fully.

671767

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

81 Registered No.

671767

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Barber

2. DATE OF DEATH: Feb 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2 H Hosp. Bmre

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 54 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: St. Marys
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Great Mills
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored	Married	2-9x	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph H. Barber
14. MOTHER'S MAIDEN NAME: Sophia Barbour
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Pyelonephritis — 2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Obstructive Bladder Mass — over 3-4 Mos

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Feb 49	Inflamatory mass surrounding bladder	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-23-, 1949 *to* 2-18-, 1949, *that I last saw the deceased alive on* 2-18, 1949 *and that death occurred at* 1:50 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul Burns M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2-22-49	Holy Faith Cem	St. Marys Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, MD	Pius B. Robinson	Damsons Md

VS 150

520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. It is especially important. Physician: please write the cause of death clearly and legibly.

G71768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

Registered No. G71768

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Emma Lillie Bragg

2. DATE OF DEATH 2/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fetterhoff Nursing Home 3502 Clifton Ave.

c. Length of stay in Baltimore 12 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 5914 Highgate Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Female	W.	Widow	Sept. 17, 1869	79				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Mass.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Chapin	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Lewis Odette, 6000 Highgate Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Hypertensive

DUE TO cardio vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11/25/40, 19__, *to* 2/18, 1949 *that I last saw the deceased alive on* 2/15, 1949, *and that death occurred at* 9:00 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Emmet Welton MD M. D.	5721 York Rd Balto 12	2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	Feb. 21/49	Loudon Park Crematory, Balto. 29, Md.	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, MD	Harry N. Nuttle	4101 Edmondson Ave

VS 150

93D

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Do not age is especially important. Physician: please write the cause of death clearly and legibly.

G71769

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 no. 1 H92

G71769

Registered No.

1. NAME OF DECEASED (Type or Print) ANNE CALLAHAN Anna H. Callahan

2. DATE OF DEATH 2/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General

C. Length of stay in Baltimore 36 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 725 Edgewood Ln #19 1608

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W		June 15-80	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Virginia	

13. FATHER'S NAME: Capt. T. W. Headley

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Clarence R. Callahan	725 Edgewood ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	10 min
DUE TO (B)		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	HTYPICAL	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Atypical pneumonia	18 Days.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/14 19 *to* 2/19, 19 49 *that I last saw the deceased alive on* 2/19, 19 49 *and that death occurred at* 9:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles J. Blasek, M. D.	Maryland General	2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 22/49	Calvary M.E. Church Cemetery	Richmond Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, M.D.	Harry A. Luttke	4101 Edmondson AVE.

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

BIRTH NO. G7170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G7170

1. NAME OF DECEASED (Type or Print): John Francis Fitzpatrick
2. DATE OF DEATH: 19 Feb. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3631 Elm Avenue
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3631 Elm Ave.
C. Length of stay in Baltimore: 68 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 831 E. Belvedere Avenue 27-48

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	June 6, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Handyman	City of Baltimore	Baltimore, Maryland	USA

13. FATHER'S NAME: John Fitzpatrick
14. MOTHER'S MAIDEN NAME: Carrie Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	—	William N. D. Fischer	831 E. Belvedere Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Artery Disease	?
DUE TO		
ANTECEDENT CAUSES. (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Wm. H. Kammer, Jr. M.D.		19 Feb. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 22, 1949	Druid Ridge	Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

94a

G717.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 470.1

G717.1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Baumann

2. DATE OF DEATH: Feb 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 545 E. 38th St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 545 E. 38th St. 9-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	MARRIED	APR. 9, 1888	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -
10B. KIND OF BUSINESS OR INDUSTRY: Bendix Radio Corp.
11. BIRTHPLACE (State or foreign country): Balto., MD
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Baumann
14. MOTHER'S MAIDEN NAME: Frances Spithle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Mary B. Baumann — ADDRESS: 545 E. 38th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B) Arteriosclerotic Cardio-Vascular Disease
DUE TO
(C) Hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 days

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 15th, 1949, to Feb 19, 1949, *that I last saw the deceased alive on* Feb 18, 1949, *and that death occurred at* 4:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Fred D. Mack M. D.
23B. ADDRESS: 513 E. 39th St
23C. DATE SIGNED: Feb 19 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-22-49
24C. NAME OF CEMETERY OR ~~CREMATORY~~: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto., MD.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 21 1949
REGISTRAR'S SIGNATURE: Dorothy Fox Williams, M.D.
25. FUNERAL DIRECTOR: Wm J. Tickner & Sons
ADDRESS: Balto., MD

VS 150

93D

G717.2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 581 0

G717.2

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frances Shipley / Hayes

2. DATE OF DEATH: 2/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Md Hosp. 22nd
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1609 St. Stephens St. 15 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	married	Oct. 5, 1897	51 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles E. Doudiken	Catherine Shipley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Mr. Wm. J. Hayes	1609 St. Stephens

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bleeding esophageal varices
DUE TO from Portal Hypertension from
(B) Cirrhosis of liver.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hyperthyroidism

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
None		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
None		

22. *I hereby certify that I attended the deceased from* 1/4/49 *to* 2/19/49 19__, *that I last saw the deceased alive on* 2/19/49, 19__, *and that death occurred at* 3:04 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. B. Riggott Jr M. D.	University Hosp.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/22/49	Cathedral Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 450

632

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied if correct age is especially important. Physician: please write the cause of death clearly and fully.

G71773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 760

Registered No. G71773

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KATE BRINGHAM CONGER

2. DATE OF DEATH: Feb. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1514 Mt. Royal Ave.
c. Length of stay in Baltimore: 10 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1514 Mt. Royal Ave. 14 01

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	widow	Aug. 7, 1884	64 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-		Ohio	

13. FATHER'S NAME: Stanley Bringham

14. MOTHER'S MAIDEN NAME: [illegible]rna Hague

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Miss Katherine E. Conger	1514 Mt. Royal Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Diabetes Mellitus	- 10 yrs.
DUE TO, ANTECEDENT CAUSES (B)	Diabetic Coma	2 hours
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	-	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No.		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* - Sept. 1947, to Feb 19, 1949, *that I last saw the deceased alive on* Feb. 17, 1949, *and that death occurred at* 5P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Earl L. Chambers M.D.	4108 Liberty Hts	2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	2/22/49	Greenmount Crematory	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Hunting for Williams, M.D.	WM. J. T CKNER & SONS	Balto., Md.

FS 150

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71774 G71774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 33 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna E Henss

2 DATE OF DEATH: Feby 19-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Convalescent Home

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4700 Harford Rd

c. Length of stay in Baltimore: Yrs. Lifetime Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md
B COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D STREET ADDRESS (If rural, give location): 2707 Southern Ave 27-12

5. SEX	6 COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single		74 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
none		Balto	USA

13. FATHER'S NAME: Adam Henss

14 MOTHER'S MAIDEN NAME: Elizabeth Goetz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16 SOCIAL SECURITY NO

17 INFORMANT: Mrs Richard Hentschell ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARTERIAL HYPERTENSION — 13 yrs.

and

(C) CEREBRAL ARTERIOSCLEROSIS — 10 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

SENILITY

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* FEB. 4, 1949 *to* FEB. 19, 1949, *that I last saw the deceased alive on* FEB. 18, 1949, *and that death occurred at* 9:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John W Machen M. D.	6331 Belair Rd. (6)	2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 23/49	Parkwood Cem	Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Hunting for Williamson	Ullrich Funeral Home	2048 Aliceanna

VS 150

236

Please write all entries in ink. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G717:5 610 G717:5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elijah Johnson

2. DATE OF DEATH: 2/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6301 Arundel Cove
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6301 Arundel Cove Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	Oct 28,	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Maryland	

13. FATHER'S NAME: David Johnson

14. MOTHER'S MAIDEN NAME: Jane Horner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	214-28-0204	Mrs Mabel Johnson	6301 Arundel Cove

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	myocarditis	
DUE TO (B)	Senility	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Hypertrophied prostate	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 5, 1948 *to* Feb 18, 1949 *that I last saw the deceased alive on* Feb 18, 1949 *and that death occurred at* 1:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Samuel Rubin M. D.	203 Cathedral St	2/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2-21-49	CEDAR HILL	[illegible] HIGHWAY

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, MD	[illegible] E. DEMING	[illegible]

VS 150

93E 715 [illegible] ST.

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

754.4

G717.6

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G717.6

Registered No.

BIRTH NO. B.C. 49-26607

1. NAME OF DECEASED (Type or Print): FRANK DiGiacomo Jr.

2. DATE OF DEATH: Feb. 18 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 6517 Eastern Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Single	Nov. 30, 1948		10 Weeks	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Maryland	U.S.A.

13. FATHER'S NAME: Frank De Giacomo

14. MOTHER'S MAIDEN NAME: Ellen - Amend

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~PNEUMONIA~~ Congestive Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Congenital cardiac hypertrophy

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Alan C Herrmann M. D.	JOHNS HOPKINS HOSPITAL	2-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/21/49	Oak Lawn	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington for Williams, M.D.	Lilly & Zeiler Inc.	403 S. Wolfe.

VS 150

157E

Please write clearly and legibly. Physician: please write the cause of death clearly and correct age is especially important.

G717.7 G717.7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Thomas H. Welles
2. DATE OF DEATH: 2/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1031 W. Cross St.
c. Length of stay in Baltimore: 38 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1031 W. Cross St. 21

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Divorced	8/25/1901	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Time Steady	Natl. Enamel + Stamping Co.	Atlantic City N.J.	U S A

13. FATHER'S NAME: Robert D. Welles
14. MOTHER'S MAIDEN NAME: Lillian M. Budden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	212-10-7764	Mrs Lillian M. Welles	1031 W. Cross St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 da

DUE TO

(B) Arteriosclerotic Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-10 1948, to 2-20, 1949, *that I last saw the deceased alive on* 2-20, 1949 *and that death occurred at* 3:30 pm., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph L Auvlentis M. D.	624 W Lexington Road	2/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/24/49	Cedar Hill Cem.	Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Hunter Williams, M.D.	John J. Cowan & Son	604 Gallows St

VS 150

1310

Physician please write the cause of death clearly and legibly. Correct age is especially important.

G7178 CERTIFICATE CORRECTED 2-23-49 V

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No.

G7178

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Granby, Willie

2 DATE OF DEATH: Feb. 17 / 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 15th Division

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: Yrs. 9 mos Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1227 Hartford Ave

5. SEX	6 COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	Negro	Widowed	(1860) 1886	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
None		Edenton, N.C	

13. FATHER'S NAME: —

14 MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Failure
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C) Hypertensive Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Multiple Aneurysms

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/9 *,* 1949 *, to* 2/17 *,* 1949 *that I last saw the deceased alive on* 2/17 *,* 1949 *. and that death occurred at* 6.25 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C DATE SIGNED
Dr Marcus W. Moore Sr M.D.	Provident Hospital	2/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Feb 22/49	[illegible] Cemetery	Edenton, N.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, M.D.	Mrs Pott A. Elliott & Daughter	1129 N. Carlton St

VS 150

93

Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and correct age is especially important. Physician:

BIRTH NO. 126679 G717'79

G717'79

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 610

Registered No.

1. NAME OF DECEASED (Type or Print): Charles Jenkins

2. DATE OF DEATH: 2- 19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-2
D. STREET ADDRESS (If rural, give location): Henryton Sanitorium 6 miles from Balt.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Widowed	June 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	

13. FATHER'S NAME: John Jenkins (D)

14. MOTHER'S MAIDEN NAME: Mary Kin- (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			B.C.H.	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Broncho- Pneumonia	
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		over
DUE TO		
(C)	Senile Prostatic Hypertrophy	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Senility	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 7- , 1949 *to* 2- 19- , 1949 *that I last saw the deceased alive on* 2- 19- 1949 *and that death occurred at* 8.30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. L. Mozes M. D.	B.C.H. 4940 Eastern Ave.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/22/49	Arbutus	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Evelyn M. Williams, M.D.	Jas. S. Kelson	1333 Druid Hill Ave

VS 150

107

Please write the cause of death clearly and legibly. Physician's certificate of cause of death is especially important.

G71780

BALTIMORE CITY HEALTH DEPARTMENT 293 G71780

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) mary Waters

2. DATE OF DEATH 2/18/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1024 Monroe

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 30 Yrs. 4 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE 1024 N monroe B. COUNTY 16 4

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto md

D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	negro	Single	Aug 1902	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	nd	Laurel Md	

13. FATHER'S NAME Frances Allen

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Goldie Johnson	927 Lucky

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Gastric Intestinal Ulcer — INTERVAL BETWEEN ONSET AND DEATH 4 mo

DUE TO

(B) Twisted Intestines

DUE TO

(C) Anemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
John Hopkins Hospital		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1948 July 19 *to* 1949 2/17 19 *, that I last saw the deceased alive on* 2/17 *, 1949, and that death occurred at* 3:30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. R. Boykin M. D.	1134 Monroe	2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-22-49		Laurel Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, M.D.	Mrs Katie B Williams Schroeder	3221

125 B

G71781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33

Registered No. G71781

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Medora Cecil Watkins

2. DATE OF DEATH: Feb. 19/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4500 Kathland Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore: 25 Yrs. (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 2[illegible]

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Widow	Sept. 13, 1869	79	5 / 6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Barnesville, Md.	

13. FATHER'S NAME: Luther Cecil

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mrs. Medora W. Ellinghaus	4500 Kathland Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: at prog 30 min

DUE TO

(b) Cerebral Arteris. scler. — Many

DUE TO

(c) Chronic Art. Hypertension — Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 25-30 years, 19__, *that I last saw the deceased alive on* Jan. 31, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
G. Carroll Sorlucco M. D.	2925 N. Charles St	20 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 21/49	Druid Ridge	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, M.D.	C. W. Mears & Son	605 N. Calvert St.

VS 150

83 R

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G71782

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

Registered No. G71782

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Cornelius Hunter

2. DATE OF DEATH: 2/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 919 S. Sharp St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 919 S. Sharp St. 23-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Divorced	4-15-1904	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		N. C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Hunter	Johanna Hunter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		James Hunter	1916 W. Mulberry St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertension

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE [signature] M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED 2/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-24-49	New Bern cem	New Bern N. C.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 21 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Elroy S. Wilson | ADDRESS: 1000 Bentley ave

VS 151

839

CERTIFICATE CORRECTED 3-16-49 / X E 9-9-8

G71783

BALTIMORE CITY HEALTH DEPARTMENT N-990.0 G71783

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK W. YOHEY

2. DATE OF DEATH February 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Foot of Bond Street

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania B. COUNTY Columbia
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bloomsburg
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	single	July 29, 1898 (Feb 20, 1899)	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Bloomsburg, Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Ephrim Yohey

14. MOTHER'S MAIDEN NAME Sarah Shutt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | W.W. #1

16. SOCIAL SECURITY NO 195-20-6821

17. INFORMANT Baker Funeral Home ADDRESS Bloomsburg, Pa.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Drowning	
DUE TO		
ANTECEDENT CAUSES (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) harbor

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Found foot of Bond Street in harbor

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 2 20 49 10.30 a.m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Probable accidental drowning

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE [signature] M.D

23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR [X]

23C. DATE SIGNED Feb. 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE 2/22/49

24C. NAME OF CEMETERY OR CREMATORY New Rosemont Cem.

24D. LOCATION (City, town, or county) (State) Bloomsburg, Pa.

DATE RECEIVED BY LOCAL REGISTRAR FEB 21 1949

REGISTRAR'S SIGNATURE [signature]

25. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

VS 1ST

183

Please write plainly, with pen and ink. Any errors or omissions should be corrected and the information should be complete. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71784 — BALTIMORE CITY HEALTH DEPARTMENT — 273.0 — G71784

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-000050 — Registered No.

1. NAME OF DECEASED (Type or Print): Iona Taylor
2. DATE OF DEATH: 2-20-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Life Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto — D. STREET ADDRESS (If rural, give location): 1711 Pierce St 19 01
5. SEX: F — 6. COLOR OR RACE: C — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 1/4/49 — 9. AGE (In years last birthday): If Under Months: 1 — Days: 16 — If Under 24 Hours: Hours — Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): — — 10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto Md — 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James H Taylo
14. MOTHER'S MAIDEN NAME: Irene Melton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: /
17. INFORMANT: Irene Melton — ADDRESS: 1711 Pierce St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation

DUE TO

(B) Aspiration of vomitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1711 Pierce St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 2-20-49 7 A. m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒ — 21F. HOW DID INJURY OCCUR? Aspiration of vomitus

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE — M.D — 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ — 23C. DATE SIGNED: 2/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 2/21/49 — 24C. NAME OF CEMETERY OR CREMATORY: Mont Auburn — 24D. LOCATION (City, town, or county) (State): Balto City

DATE RECEIVED BY LOCAL REGISTRAR: FEB 21 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: L L Brown & Son — ADDRESS: 108 W Montgomery St

VS 151

1950

G71785 G71785

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 410 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anna Herr.

2. DATE OF DEATH 2-21-49

3. PLACE OF DEATH: A. Baltimore City, Maryland St. Agnes

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital Caton ave.

C. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D STREET ADDRESS (If rural, give location) 115. Wickham Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W.	Married	1-31-25	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife.	Housewife.	MARYLAND	

13. FATHER'S NAME Charles Schaeffer

14. MOTHER'S MAIDEN NAME Winifred Downs.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		McDONALD C. HERR 115 WICKHAM RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic heart disease
DUE TO c aortic & mitral
(B) stenosis c cardiac failure
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: ? yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 23, 1949 *to* Feb 21, 1949, *that I last saw the deceased alive on* Feb 20, 1949, *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sidney Johnson Vander M. D.	St. Agnes Hospital	2/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Feb. 24 '49	LOUDON PARK	BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Thurston Von Williams, M.D.	Henry A. Wetzel	4101 Edmondson Ave

VS 150

9212

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1347 Registered No. G71786

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Amos Hartwell Collins

2. DATE OF DEATH: February 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U. S. Marine Hospital

c. Length of stay in Baltimore: 121 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Tennessee
B COUNTY: Lauderdale
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ripley
D STREET ADDRESS (If rural, give location): -

5. SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year Months, Days	If Under 24 Hours Hours, Min.
M	W	divorced	Jan 16, 1906	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
deckhand	seafaring	Tennessee	USA

13. FATHER'S NAME: John Collins

14 MOTHER'S MAIDEN NAME: Frances ?

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): unknown

16. SOCIAL SECURITY NO: 410-01-0452

17 INFORMANT: Records, U S Marine Hospital, Balto, Md ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Histoplasmosis — Unknown

DUE TO

Contributory disease:

(B) Hodgkin's disease — Unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* October 21, 1948 *to* February 19, 49 *that I last saw the deceased alive on* February 19, 49 *and that death occurred at* 8:35a *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
John L. Wilson M. D.	U. S. Marine Hospital, Balto,	2/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Removal	2/22/49	Memphis, Tenn.	Memphis, Tenn.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, M.D.	Wm Cook Inc.	217 St. Paul St Balto. 2.

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G71787

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 334 Registered No. G71787

1. NAME OF DECEASED (Type or Print): Lydia A. Cooper

2. DATE OF DEATH: 2/20/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1008 W. Lexington St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1008 W. Lexington St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1008 W. Lexington St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Colored	Widowed	June 4, 1871	77 78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Boyd
14. MOTHER'S MAIDEN NAME: Spriddle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Eugene Cooper ADDRESS: 472 Cummings st.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebro-Vascular-Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertension
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
General Debility

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/17 19 49 *to* 2/20 19 49, *that I last saw the deceased alive on* 2/17 19 49, *and that death occurred at* 5 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Luster Grant M. D.
23B. ADDRESS: 691 N. Carrollton
23C. DATE SIGNED: 2/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/23/49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Pk.
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William L. Chatman Jr. ADDRESS: 1901 McCulloh St

VS 150

8-3a

G71788

G71788

BC. 49-03531

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

776 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Davis

2. DATE OF DEATH: Feb. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1505 W. Mulberry Street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 19-01
D. STREET ADDRESS (If rural, give location): 1505 W. Mulberry Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Fe	C		2/19/49			15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Balto, Md	

13. FATHER'S NAME: Geo. Davis

14. MOTHER'S MAIDEN NAME: Helen Julia Roundtree

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	—	Mrs. Helen Davis	1505 W. Mulberry

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Premature Birth — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 19, 1949 *to* Feb. 19, 1949, *that I last saw the deceased alive on* Feb. 19, 1949, *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ralph W. Northrop M.D.	[redacted] Arlington Street	2/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
		[redacted]	FEB 21 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

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Physician please write the cause of death clearly and legibly. Correct age is especially important.

G71789 — BALTIMORE CITY HEALTH DEPARTMENT — G71789

BIRTH NO. — CERTIFICATE OF DEATH 423.0 — Registered No.

1. NAME OF DECEASED (Type or Print): Agatha (AGNES) ZARZECKA

2. DATE OF DEATH: 2/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3819 Hudson St #24

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): (WIDOWED)
8. DATE OF BIRTH: 2/5/84
9. AGE (In years last birthday): 65 — If Under 1 Year: Months, Days: 0 14 — If Under 24 Hours: Hours, Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Wierkowski
14. MOTHER'S MAIDEN NAME: Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. John Rybka — ADDRESS: 3819 Hudson St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/27/49 to 2/19/49, that I last saw the deceased alive on 2/19/49, and that death occurred at 7:20 P m., from the causes and on the date stated above.

23A. SIGNATURE: Charles J. Blanck, M. D.
23B. ADDRESS: Maryland General
23C. DATE SIGNED: 2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/23/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Balto.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 21 1949
REGISTRAR'S SIGNATURE: Evelyn Williams M.D.
25. FUNERAL DIRECTOR: E. J. Fanning & Son — ADDRESS: 1938 E. Lafayette Ave

VS 150

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G71790

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 177

G71790 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Martin D. Trainor

2. DATE OF DEATH: Feb 19th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 5907 Sefton Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 5907 Sefton Ave. 23 44

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 14th 1866
9. AGE (In years last birthday): 82 — If Under 1 Year: Months 4, Days 5 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Photographer
10B. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Owen L. Trainor
14. MOTHER'S MAIDEN NAME: Julia Holmes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Mary E. Trainor ADDRESS: 5907 Sefton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Prostate Gland — INTERVAL BETWEEN ONSET AND DEATH: One year
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Generalized arteriosclerosis

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1948 *to* Feb. 19, 1949 *that I last saw the deceased alive on* Feb 18, 1949 *and that death occurred at* 5:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm. H. Freeman, M. D.
23B. ADDRESS: 1402 E. Lanvale St
23C. DATE SIGNED: Feb 21 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/22/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: E. J. Fanning & Son
ADDRESS: 1938 E. Lafayette Ave

VS 150

516

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71791

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4m-1

G71791 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Frances Carter

2 DATE OF DEATH 2/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore 11 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE Md. B COUNTY [illegible]
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Indian Head
D STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	C	Married	7/13/01	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Barber		Md.	U S A

13. FATHER'S NAME: James F. Carter

14 MOTHER'S MAIDEN NAME: Hattie Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
unknown		James Frances Carter	Indian Head Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Occlusion	2 days
DUE TO (B)	Coronary Sclerosis	unknown
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Generalized Arteriosclerosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Cyst of head of pancreas Ascites	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
2/12/49	Cyst of head of pancreas - Ascites	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 2/19, 1949 *to* 2/20, 1949, *that I last saw the deceased alive on* 2/20, 1949, *and that death occurred at* 9:35 4m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
C. W. Hoffler M. D.	Provident Hosp.	2-22-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Remove	2/21/49		Washington DC.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 21 1949	Acting for Baltimore, Md.	Barnes & Matthews	614-4½ St. S.W. Wash. 4 DC

VS 150

128

Physician: please write the cause of death clearly and legibly. Exact age is especially important.

G71792

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4-20.1

G71792 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clarence A. Steffe

2. DATE OF DEATH 2/18/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1949 Wilkens Ave.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 1949 Wilkens Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		Sept. 1884	64 - 62 -		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist.
10B. KIND OF BUSINESS OR INDUSTRY B & O. R.R.
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William J. Steffe
14. MOTHER'S MAIDEN NAME Lillian Andrews.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 705-05-080
17. INFORMANT Lillian E. Stagge ADDRESS Pasadena Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 16, 1949, *to* Feb 18, 1949, *that I last saw the deceased alive on* Feb 17, 1949, *and that death occurred at* 11 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE Richard C Nietsch M. D.
23B. ADDRESS 2517 W. Lanvale
23C. DATE SIGNED 2/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 2/22/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or County) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 22 1949
REGISTRAR'S SIGNATURE Remington Williams, M.D.
25. FUNERAL DIRECTOR C. B. Hughes & Son ADDRESS 1300 Eutaw

VS 150

94a

Please write the cause of death clearly and fully. Physician: please write the cause of death clearly and fully. Physician: please write the cause of death clearly and fully. Physician:

G71793 G71793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4-22.

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Julius Schultze

2. DATE OF DEATH 2-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 339 Yale Ave
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 339 Yale Ave. 20-C-8

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	Jan. 27-1869	80	/	/

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker.	Bakery	Germany	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frederick Schultze	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Mrs. Lenora S. Pugh - 339 Yale Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Occlusion	3 days.
DUE TO		
(B)	Arteriosclerosis	
DUE TO		
(C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/15, 1949 *to* 2-19, 1949 *that I last saw the deceased alive on* 2-19, 1949 *and that death occurred at* 4:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Alvah H. Lemmon M. D.	4209 Fredrick Ave	2-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/22/49	Loudon Park	Baltimore - Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 22 1949	Huntington Williams, M.D.	F. B. Keppel & Son 1300 Eutaw Place 17

VS 150

94a

G71794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 203

Registered No. G71794

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hossie Brown

2. DATE OF DEATH: 2-18-49.

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1447 Mt Hour Court

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp. + Free Dispensary

c. Length of stay in Baltimore: 64 YEARS (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	Apr. 7, 1901	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waitress	-	North Carolina	

13. FATHER'S NAME: Oscar Campbell

14. MOTHER'S MAIDEN NAME: Elizabeth ? (Maiden name unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Hospital Records.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Myeloma — DUE TO

ANTECEDENT CAUSES

(B) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 Months.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-24-49 19__, *to* 2-18-49 19__, *that I last saw the deceased alive on* 2-17-49 19__, *and that death occurred at* 8:30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE.	23B. ADDRESS	23C. DATE SIGNED
William C. Rogue M. D.	Provident Hospital	2-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/22/49	Mt Auburn	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Turlington Williams M.D.	Geo. L. Nelson	1303 Pleasant St

VS 150

55E

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71795

G71795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NORA BLAKE

2. DATE OF DEATH Feb 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 825 Hollins St. 1503

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W.	Married	March 5 1884	64	11 15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At home	Maryland	U.S.A.

13. FATHER'S NAME Jesse Chance

14. MOTHER'S MAIDEN NAME Ella Slaughter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized carcinomatosis

DUE TO

(B) Bronchogenic carcinoma

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 14 1949 *to* Feb 20, 1949, *that I last saw the deceased alive on* Feb 20, 1949 *and that death occurred at* 2:25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. Siwinski M. D.	Mercy Hosp.	Feb 21 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/23/49	Mt. Olivet	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 22 1949	[illegible] Huntingtown, Md.	Wm. Cook Inc. 127 St. Paul St.

VS 150

47c

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71796

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4-20-1

G71796
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHESTER ARTHUR WARREN

2. DATE OF DEATH: Feb. 18, 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2757 The Alameda

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Life Mos. Days

D. STREET ADDRESS (If rural, give location): 2757 The Alameda 9-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	W	Married	Dec. 13, 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Batto. City

10B. KIND OF BUSINESS OR INDUSTRY: Order Dept

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lawrence Warren

14. MOTHER'S MAIDEN NAME: Katherine Perry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension — DUE TO Arteriosclerosis

(C) Nephritis

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1948 *to* Feb 18, 1949, *that I last saw the deceased alive on* Feb 18, 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lovett Fisher M. D.

23B. ADDRESS: 1823 N Washington St

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/22/49

24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 22 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND

1310

Correct age is especially important. Physician: please write the cause of death clearly and forcibly.

BIRTH NO. G71797

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

334 Registered No. 71797

1. NAME OF DECEASED (Type or Print): FANNIE (FAGA) KUPERSMIDT
2. DATE OF DEATH: FEB. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MT. SINAI HOME
c. Length of stay in Baltimore: 49 YEARS (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 22-16
D. STREET ADDRESS (If rural, give location): 4613 PARK HEIGHTS AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
FEMALE	WHITE	WIDOW	1864	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	RUSSIA	USA

13. FATHER'S NAME: ISAAC EPSTEIN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Mr Harry Oscheroff	1913 Ruxton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Apoplexy - Terminal Pneumonia	24 hrs.
DUE TO (B)	General arteriosclerosis	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	senility	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	None	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 1947 *to* Feb 21, 1949 *that I last saw the deceased alive on* 2-21, 1949 *and that death occurred at* 12:35 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr. Bernard Cohen M. D.	Marchmont Apt	2-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	2/22/49	HEBREW MT. CARMEL	GERMAN Hill Road MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Augustus Williams M.D.	Sol. Levinson & Bros.	1126 W. North Ave.

VS 150

83a

Correct age is especially important. Physician please write the cause of death clearly and legibly.

G71798 ✓ X G71798

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4-22-1

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ELLA MAY HARMON

2. DATE OF DEATH: February 19,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1708 N. Eutaw Street
Finkelstein Nursing Home
C. Length of stay in Baltimore: 1 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryladd
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): York Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed	Jan.7,1870	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Balto.Co., Maryland	USA

13. FATHER'S NAME: John Burton

14. MOTHER'S MAIDEN NAME: Mary Jane Burton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No	None	Miss Ellen Louise Bell, Balto.11, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cardiac decompensation	10 mos.
DUE TO (B)	Auricular fibrillation	various stages
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Arteriosclerosis, Senility,	unk. unk.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	none	none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Apl 1, 19 48 *to* Feb 19, 19 49 *that I last saw the deceased alive on* 2/18, 19 49, *and that death occurred at* 1:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Burnett G. Stoer M. D.	Leatherville	2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb.22,1949	St. Mary's P.E.Cemetery	Hampden, Balto., Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 22 1949	Huntington for Williams, M.D.	John Burns' Sons, Towson, Maryland

95c

Bal 3930 Ed 9

G71799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71799

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Henry WICKENS

2. DATE OF DEATH: Feb 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U. S. Marine Hospital

c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: BALTO. 7
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 324 Flannery Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
Male	White	Single	Nov 19, 1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Maryland	USA

13. FATHER'S NAME: ? Arcemus.

14. MOTHER'S MAIDEN NAME: Catherine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	WW I	?	Records, U. S. Marine Hospital	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Bronchogenic carcinoma of the right lung with metastases	unkn
DUE TO (B)		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	no	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Feb 8, 1949, *to* Feb 19, 1949, *that I last saw the deceased alive on* Feb 19, 1949, *and that death occurred at* 6:45A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David E. Leftwich M. D.	U. S. Marine Hospital	2/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial.	2/22/49	Woodlawn.	Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 22 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Paul E. Chenoweth Jr-3615-17 Cheatnut Ave.

ADDRESS: 47D

Please write the cause of death clearly and legibly. Physician, please write the cause of death clearly and legibly. Physician, please write the cause of death clearly and legibly. Physician,

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G71800 | Registered No. G71800

1. NAME OF DECEASED (Type or Print): Charles L. Aidt
2. DATE OF DEATH: Feb. 20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 305 E. Belevedere Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 305 E. Belvedere Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Sept. 11, 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10B. KIND OF BUSINESS OR INDUSTRY: Hendler Creamery
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Gustav F. Aidt
14. MOTHER'S MAIDEN NAME: Lucy J. Murray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Mrs. Mamie Aidt, 305 E. Belvedere Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma rectum	9 months
DUE TO (B)	also Liver metastases -	9 months
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* May, 1949, to 20 Feb., 1949, *that I last saw the deceased alive on* Feb 19, 1949, *and that death occurred at* 7 30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. Ellsworth Cook M. D.
23B. ADDRESS: 2431 Maryland Ave.
23C. DATE SIGNED: 21 Feb. '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 23/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry A. Winterling
ADDRESS: 2101 Edmondson Ave.

467

BIRTH NO. G71801

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71801

1. NAME OF DECEASED (Type or Print): Sister Helen of St Michael
2. DATE OF DEATH: Feb. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St 10-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F.	W.	S.	Nov 5, 1869	79 80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard Ranclippe
14. MOTHER'S MAIDEN NAME: Ely Wilcock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Sister Ignatius ADDRESS: 1200 Valley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Chronic Myocarditis	5 yrs
DUE TO		
(B)	Arterio Sclerosis -	10 yrs
DUE TO		
(C)	Chronic Fibroid Tuberculosis	10 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 10 - 1945 *to* Feb 20, 1949, *that I last saw the deceased alive on* Feb 20, 1949, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E Gill Hall M. D.	1621 E North Ave	Feb 21-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Feb 23, 1949	Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS.
FEB 22 1949	Huntington Williams, M.D.	Robt Windefeld 901 E Pratt St

VS 150

136

Correct age if unknown. Important. Physician: please write the cause of death clearly and legibly.

G71802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49

G71802 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Luke Lucas Kulacki

2. DATE OF DEATH: February 21-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 126 S.Patterson Prk Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 126 S.Patterson Park Ave 1-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	Nov 15-1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ignatius Kulacki
14. MOTHER'S MAIDEN NAME: Tillie Borek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Frances Kulacki ADDRESS: 126 S.Patterson Prk Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Senility	
DUE TO (B)	Myocardial failure	4 Yrs.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Pneumonia-Bronchio-Trach	2 hours
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1 *,* 19 48 *to* Feb 21 *,* 19 49 *, that I last saw the deceased alive on* Feb 21 *,* 19 49 *, and that death occurred at* 3:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leo L. Kulacki M.D.
23B. ADDRESS: 126 S. Patterson Park Ave.
23C. DATE SIGNED: Feb. 24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 24-1949
24C. NAME OF CEMETERY: ST. STANISLAUS
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: George A Weber ADDRESS: 705 So Bond st

FEB 22 1950

162 C

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

G71803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71803

E-822.0 N-803.2

BIRTH NO. G71803

1. NAME OF DECEASED (Type or Print): Louis W. Madden

2. DATE OF DEATH: 2/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Life. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3416 Stafford St. 20-38

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married.	March 23 1925	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Grocery Store.	Baltimore - Md.	U.S.A.

13. FATHER'S NAME: Edgar M. Madden Sr.
14. MOTHER'S MAIDEN NAME: Viola Bernhardt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes.	World War No. 2		Mrs. Mary Dolores Madden	3416 Stafford St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Crushed Skull
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street	South Bound on Hilton Ave.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
2 20 49 approx 4 P.M.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Truck overturned

22. *I certify that I took charge of the remains described above, held an* Inspection Only, *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Emil L. Beyer M.D.	☒	2/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial.	February 23 1949	Balto. National Cem.	Baltimore - Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Lucretia Williams, M.D.	Charles J. Schwabz	3512 Fed'k. Ave.

VS 15T

170C

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 2-26-49

G71804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443

Registered No. G71804

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Wm. B. McGrann

2. DATE OF DEATH: 2-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D STREET ADDRESS (If rural, give location): 413 Chanter Oak 27-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	W	9-15-83	65	5 6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bar tender

10B. KIND OF BUSINESS OR INDUSTRY: Bloch Brewery

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis McGrann

14. MOTHER'S MAIDEN NAME: Julia Donohue

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 214-01-9358

17 INFORMANT: Theresa McGrann ADDRESS same (sister)

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardio - vasculorenal disease with cardiac decompensation grade IV — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs +

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: O Cruelty

19A. DATE OF OPERATION: 2- 4

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-20-1949 *to* 2-21-1949 *that I last saw the deceased alive on* 2-21-1949, *and that death occurred at* 5:00 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. P. Judd M. D.

23B ADDRESS: Mercy Hospital

23C DATE SIGNED: 2-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb 24 1949

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Balto., Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 27 1949

REGISTRAR'S SIGNATURE: Huntington for Williams M.D.

25. FUNERAL DIRECTOR: Henry W. Jenkins, Jno. C. ADDRESS: 4905 York Rd

VS 150

1212

Correct age is especially important. Physicians: please write the cause of death clearly and fully.

GM. 39254 G71805

BALTIMORE CITY HEALTH DEPARTMENT 450.0 G71805

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Matthew Russell

2. DATE OF DEATH 2- 20- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 10 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 900 E. Baltimore St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	W	1860 ?	89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Ireland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Matthew Russell	Helen Kennedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Records Balto. City Hospitals	910 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		(INTERVAL BETWEEN ONSET AND DEATH)
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchopneumonia	4 days
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Generalized Arteriosclerosis	5 Yrs.
DUE TO		
	(C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9- 11- , 1944, *to* 2- 20- , 1949, *that I last saw the deceased alive on* 2- 20 1949, *and that death occurred at* 2:45A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. O. Cooley M. D.	B.C.H. 4940 Eastern Ave	2-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-21-49	Mt. Carmel Cem	5712 O'Donnell St.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Huntington Williams, M.D.	Charles S. Zerler	901 S. Conkling St.

107

G71806

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 43 Registered No. G71806

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES M. BOWEN

2. DATE OF DEATH: 2/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL

c. Length of stay in Baltimore: Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 7012 BELCLARE ROAD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W		OCT 12, 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	TOOL ROOM TENDER	Md.	

13. FATHER'S NAME: CHARLES BOWEN

14. MOTHER'S MAIDEN NAME: LIDDY FAIR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 216-10-3183

17. INFORMANT: Nora E. Bowen ADDRESS: 7012 Belclare Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asthmatic & Bronchitis

DUE TO

(B) Adhesive pericarditis;

DUE TO Myocardial fibrosis

(C) Pulmonary Emphysema & fibrosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/13, 1949 *to* 2/21, 1949 *that I last saw the deceased alive on* 2/21, 1949 *and that death occurred at* 5:10 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald W. Winter M. D.	Church Home & Hosp.	2/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 24th 1949	Pikesville Church Ln	Falls Road. Balto Co.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Huntington Williams, M.D.	John C. Mosan	3000 E. Baltimore St

VS 150

93D

G71807 ✓ G71807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 6 10 Registered No.

1. NAME OF DECEASED (Type or Print) BENJAMIN BRANNOCK

2 DATE OF DEATH FEB. 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP.

c. Length of stay in Baltimore 30 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE MARYLAND B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 109 So. Robinson ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	MARRIED	8-26-1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
RETIRED		MARYLAND	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
THOMAS BRANNOCK	MARY MILLS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
		MRS CAROLINE M. BRANNOCK	109 So ROBINSON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	UREMIA (RENAL FAILURE)	?
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	BENIGN HYPERTROPHY OF PROSTATE	4 YEARS +
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	BRONCHOPNEUMONIA; ARTERIOSCLEROTIC HEART DISEASE	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* FEB. 13, 1949 *to* Feb. 20, 1949, *that I last saw the deceased alive on* FEB. 20, 1949, *and that death occurred at* 2:05 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Samuel Lerman M. D.	Sinai Hospital	Feb. 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
BURIAL	2-23-49	OAKLAWN	BALTIMORE Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Lexington Williams, M.D.	John A. Moran	3006 Falls Rd

VS 150

937

G71808

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 420.

G71808 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James W. Lane

2. DATE OF DEATH: 2-20-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): #8 N. Milton Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	W	Married	11-11-1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17 INFORMANT: Genveive M. Lane ADDRESS: #8 N. Milton Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Congestive heart failure	
DUE TO		
ANTECEDENT CAUSES	(B) Coronary Occlusion	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) Generalized Arteriosclerotic Cardiovascular Disease	

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 2/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-23-49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Moran
ADDRESS: 3000 E. Balt. St. Baltimore Md.

VS 151

93)

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71809 G71809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 760

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BARBARA GICK.

2. DATE OF DEATH FEBRUARY 21 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE CITY.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) KIRKLEIGH VILLA.

c. Length of stay in Baltimore 65 YEARS. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE CITY.
D. STREET ADDRESS (If rural, give location) 3538 OLD YORK ROAD. 9 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	WIDOW	6-27-18[illegible]	7[illegible]		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Germany	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Matthew Rosenbaum	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Joseph Sick	2733 Harlem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	DIABETES MELLITUS. (COMA)	1942.
DUE TO (B)		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	CHRONIC INTERSTIAL NEPTHRITIS	1945.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	ARTERIOR SCLEROSIS	1945.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE	NONE	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* FEBRUARY 19 19 49 *to* FEBY 21, 19 49, *that I last saw the deceased alive on* FEBY 21 19 49, *and that death occurred at* 11.45 A. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas. F. Blanton M.D.	3013 ST PAUL STREET.	FEBY 21 194[illegible]

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-24-49	Cathedral Cem.	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Countersigned for Williams, M.D.	George A. Farley	

VS 150

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To be approved by medical examiner ✓

G71810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G71810 — Registered No. 4m.o

1. NAME OF DECEASED (Type or Print): Mr. JOSHUA WILSON RICHARDSON
2. DATE OF DEATH: 2-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSP 33rd & Calvert St.
c. Length of stay in Baltimore: ? Yrs. ? Mos. ? Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1206 N Calvert St. 11-61

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	1-15-1871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?	?	Maryland	USA

13. FATHER'S NAME: Hall Richardson
14. MOTHER'S MAIDEN NAME: Alice Ann Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
?	?	?	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial insufficiency — DUE TO
(B) Arteriosclerotic Heart Disease — DUE TO
(C) (Heart block)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Heart block - Fr. left hip - Op. on 2-21-49

INTERVAL BETWEEN ONSET AND DEATH: ? ?

INTRATROCHANTERIC

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2-21-49	Fr. left hip - intertrochanteric	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
accident	home	1206 N Calvert St

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
2-19-49 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	fell and broke 11/1.

22. *I hereby certify that I attended the deceased from* 2-19-49, 19__, *to* 2-21-49, 19__, *that I last saw the deceased alive on* 2-21-49 19__, *and that death occurred at* 4:12 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marshall D. Carter, M.D.	Union Memorial Hosp.	2-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2-23-49	Churchville Presbyterian	Churchville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Functioning for Williams, M.D.	John O. Mitchell & Son	1900 Eutaw Place

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Approved Geo. S. Merrill M.D. (Asst. C. Medical Examiner)

Caution: It is especially important that physicians please write the cause of death clearly and legibly.

G71811 ✓ G71811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 174

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Pearce Brooks

2. DATE OF DEATH Feb. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hospital for the Women of Maryland
c. Length of stay in Baltimore 26 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sparks
D. STREET ADDRESS (If rural, give location) None given

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
F	W	Married	Sept. 13, 1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	—	Maryland.	U.S.

13. FATHER'S NAME Daniel Pearce

14. MOTHER'S MAIDEN NAME Anna Scott.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	—		The deceased Elizabeth Pearce Brooks	Sparks, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Neoplasm of uterus with metastases (Probably Scirrhous) — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Feb. 3, 1949	Neoplastic disease of uterus with generalized peritoneal + Abd. organ Metastases	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None	None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Jan. 25, 1949 *to* Feb. 21, 1949 *that I last saw the deceased alive on* Feb. 21, 1949, *and that death occurred at* 7:26 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas H. Schlosser M. D.	Hosp. Women Md	Feb. 21 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-23-49	Lovegrove Methodist Cemetery	Sparks, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Funeral for Williams, M.D.	John O. Mitchell Sons	1900 Eutaw Place

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48 B

G71812 ✓ ✓ G71812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 37

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Hattie Mae Windsor

2. DATE OF DEATH: Feb - 22 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. Women Maryland
C. Length of stay in Baltimore: Life — 57 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2726 W. Mosher St. 16 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F M.	W.	Single	Apr 4 1491	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Companion	None	Baltimore Maryland	U S A

13. FATHER'S NAME: William W. Windsor

14. MOTHER'S MAIDEN NAME: Sarah Lichle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	—	—	Mrs B. H. Duff	2726 W. Mosher

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Meningitis (organism not known)	3 wks
DUE TO (B)	Otitis Media	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Calcified Tuberculosis	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
- m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Feb · 19 · *1949, to* Feb · 22 · *1949, that I last saw the deceased alive on* Feb · 22 *1949, and that death occurred at* 2 40 a *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George J. Schlesinger M. D.	Hosp Women Md.	11 · 22 · 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/26/49	Loudon Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Transferred for Hattiesville, Md	John T. Standing	2700 Edmondson Ave

VS 450

89a

G71813 CERTIFICATE CORRECTED 3-3-49 G71813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) OWEN REED

2. DATE OF DEATH Feb. 20 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1330 James St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — — —

c. Length of stay in Baltimore 73 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1330 James St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	Dec. 17 1875	72 73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. clerk.	Court.	Balto. Md.	—

13. FATHER'S NAME Owen Reed

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	—	Miss Bertha Reed	1330 James St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 4 Mo

DUE TO

(B) Arteria Sclerosis — 2

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Emphysema — 2

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 17 1948 *to* Feb 20 1949, *that I last saw the deceased alive on* Feb 15 1949, *and that death occurred at* 12:45 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James K. Katzenberg M. D.	721 Medical Arts Bldg	2/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 23-49	Loudon Park Cem	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Registrar for Williams, M.D.	Geo L. Beyer Jr	1512 Hollins St

VS 150

93D

G7181-4 ✓ G7181-4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH, 77

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HOWARD F. PROCTOR

2. DATE OF DEATH: FEB. 21 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2013 W. LANVALE ST.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): — — — —

c. Length of stay in Baltimore: Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2013 W. LANVALE ST. 16 04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
MALE	WHITE	MARRIED	OCT. 20-1882	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): BALTIMORE

12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME: MILLARD F. PROCTOR

14. MOTHER'S MAIDEN NAME: HARRIETT ASH.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

17. INFORMANT: MRS. MARIE C. PROCTOR ADDRESS: 2013 W LANVALE ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma, prostate — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B)

DUE TO

(C) Arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 2, 1948, *to* Feb. 21, 1949, *that I last saw the deceased alive on* Feb. 15, 1949, *and that death occurred at* 7:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
DeWitt Langfelder M. D.	450 N. Payson St.	2/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 24-49	Lorraine Cemetery	Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	for Williams, M.D.	Geo. L. Beyer Jr	1512 Hollins St

VS-150

51B

G71815

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71815
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Claude Howell

2. DATE OF DEATH: 2/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bel-air Md Rural
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W		August 11 1909	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bull Dozer Operator	Construction	Ash Co., N.C.	U.S.

13. FATHER'S NAME: James H. Howell

14. MOTHER'S MAIDEN NAME: Laura Parson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mr James Howell ADDRESS Bel Air Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull

due to Intracranial hemorrhage

due to Fractured pelvis

due to Contusion of brain.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Belair Rd. going North

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 2-21-49 11:30P.M.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from* natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].

23A. SIGNATURE: George L. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 2/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 25 1949	Oak Grove	Harford Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 22 1949

REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.

25. FUNERAL DIRECTOR: H.S. Bailey ADDRESS: Darlington Md

VS 151

170c

Cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly.

G71816 ✓ G71816

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 42

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Walter Anton Pieramon

2. DATE OF DEATH: Jan. Feb. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1042 Patapsco St. 43-07

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1042 Patapsco St.

c. Length of stay in Baltimore: Life — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Mlat	married	June 15, 1884	64	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed	—	Balto., Md.	U.S.A.

13. FATHER'S NAME: George Pieramon

14. MOTHER'S MAIDEN NAME: Johanna Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	215-05-0535	Mrs Betty Ann Pieramon	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Arteriosclerotic Heart Disease ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic nephritis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 10 1948 to Feb 20, 1949, *that I last saw the deceased alive on* Feb 18, 1949 *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James E. Peterman M. D.	126 Hanover St.	Feb 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Wed, Feb 23, 1949	Cedar Hill Cem.	Anne Arundel Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Huntington Williams, M.D.	C. J. Bowers Evans	1400 S. Charles St.

VS 150

937

G71817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71817 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie Gertrude McFarland

2. DATE OF DEATH: Feb-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 616-E-33-St-

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at Lirhome

c. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 616-E-33-St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Abt-7-28-1883
9. AGE (In years last birthday): 65 yrs
If under 1 Year: Months Days
If under 1 day: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Michael J Reilley
14 MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: NONE
17 INFORMANT: Mrs Mary J Martin (Sister) ADDRESS 616 E 33 St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchial Pneumonia
DUE TO Senility contributed to produce
(B) Cardio Renal vascular disease
DUE TO Old age
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

INTERVAL BETWEEN ONSET AND DEATH: 3 days; 10 yrs

19A. DATE OF OPERATION: No
19B. MAJOR FINDINGS OF OPERATION: No
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): No
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1 19[illegible] *to* Feb 21 19[illegible] *that I last saw the deceased alive on* Feb 20 19[illegible] *and that death occurred at* 7.55 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: P L Kenyon M. D.
23B. ADDRESS: Westminster Md
23C DATE SIGNED: 2-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-24-49
24C NAME OF CEMETERY OR CREMATORY: New Lakewood
24D LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: Stuart Mowell
ADDRESS: 1080 North ..

121a

G71818

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 134 Registered No. G71818

1. NAME OF DECEASED (Type or Print): Mary Emma Turner
2. DATE OF DEATH: 2/22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 680 Josephine St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): -
c. Length of stay in Baltimore: 1 yr. 1 mo.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: St. Mary's
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Leonardtown
D. STREET ADDRESS (If rural, give location): -

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	Col.	Widowed	1887	62	-	-

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Same	Maryland	U. S. A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Susan Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no	none	Rosie Curtis	680 Josephine St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Endocarditis	months
DUE TO (B)	Bronchitis	2 weeks
DUE TO (C)		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
-	-	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
-	-	-

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
- m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	-

22. *I hereby certify that I attended the deceased from* Feb 1 1949 *to* 2/22/49, 19___, *that I last saw the deceased alive on* 2/22/49 19___, *and that death occurred at* 1 PM, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter J. Loomis M. D.	Hollywood Md	2/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 25, '49	Medleys Neck	Medleys Neck.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	W. C. Mattingly Sons	Leonardtown Md.

VS 150

W. C. Mattingly Sons, Leonardtown, Md.

92E

G71819 Amd Certe

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith
(c) Hospital or institution:
Motherhouse of Notre Dame
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 weeks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3123 Hudson
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Sr. Mary Ottilia Schnell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1889

8. AGE: Years	Months	Days	If less than one day
60	1	3	hr. min.

9. Birthplace Weesport Pa.
(Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name Oliver Schnell
13. Birthplace Weesport Pa.

MOTHER
14. Maiden Name Priscilla Roth
15. Birthplace Weesport Pa.

16 (a) Informant Sr. M. Stan. Kostka
(b) Address 901 Aisquith Street

17 (a) Burial (b) Date thereof 2-23-49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Glyndon, Maryland

18 (a) Funeral director Geo. M. Smith & Son
(b) Address 847 N. Wolfe Street

19 FEB 23 1949 (b)
(Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1949 at 5.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1949 to 19
and that I last saw her alive on July 21 1949

Immediate cause of death — Duration

Congestive heart failure
Due to Arteriosclerosis
Due to Chronic Myocardial Hypertrophy and dilatation heart
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis J. Kirby M. D.
Address 1108 Northern Pkwy Date signed 2/22/49

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 2-28-49

BIRTH NO. 71820 Dr. Hardred

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71820

1. NAME OF DECEASED (Type or Print)	NELLIE CATHERINE SCHADEWALD
2. DATE OF DEATH	Feb. 19, 1949
3. PLACE OF DEATH: A.	Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	3200 Moravia Avenue
c. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	3200 Moravia Avenue
5. SEX	female
6. COLOR OR RACE	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	married
8. DATE OF BIRTH	Jan 29, ~~1879~~ 1880
9. AGE (In years last birthday)	(70) 69
If Under 1 Year: Months, Days	
If Under 24 Hours: Hours, Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	at home
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	Maryaville, Penna
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	? Willard
14. MOTHER'S MAIDEN NAME	Cora L. Bull
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO	
17. INFORMANT ADDRESS	Mr. August Schadewald, 3200 Moravia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
I (A)	Acute myocarditis	10 days
DUE TO (B)	Hypertension	7 years
DUE TO (C)	Arteriosclerosis	?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 28, 1943 *to* Feb. 19, 1949 *that I last saw the deceased alive on* Feb. 19, 1949, *and that death occurred at* 9.30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	H. T. Harbold	
23B. ADDRESS	4706 Harford Road	
23C. DATE SIGNED	2-21-49	
24A. BURIAL, CREMATION, REMOVAL (Specify)	Burial	
24B. DATE	2-23-49	
24C. NAME OF CEMETERY OR CREMATORY	Loudon Park	
24D. LOCATION (City, town, or county) (State)	Baltimore, Maryland	
DATE RECEIVED BY LOCAL REGISTRAR	FEB 23 1949	
REGISTRAR'S SIGNATURE	Huntington Williams, M.D.	
25. FUNERAL DIRECTOR ADDRESS	Leonard J. Ruck, 5305 Harford Road.	

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Dr. Harbold

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 001

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): JAMES MAC DONAL HACKETT

2. DATE OF DEATH: Feb. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pineridge Nursing Home 4703 Hampnett Avenue

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4708 Pilgrim Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
male	white	married	July 26, 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS: Mrs. Margaret Hackett, 4708 Pilgrim

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Tuberculosis of lungs	10 years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) (? Acid tank worker)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) Arteriosclerosis	

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Jan 18, 1944 *to* Feb 21, 1949 *that I last saw the deceased alive on* FEBRUARY 20, 1949 *and that death occurred at* 10:03 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: H. L. Harbold M. D.
23B. ADDRESS: 4706 Harford Road
23C. DATE SIGNED: 2-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2- -49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: FEB 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Leonard J. Ruck 5305 Harford Road.

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Dr. Grenzer
1402 E. Lanvale

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 177

Registered No. G71822

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE HARRY STETTES

2. DATE OF DEATH: Feb. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3014 Hamilton Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3014 Hamilton Avenue 27-44.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	May 15,1898	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	B.& O.R.R.	Baltimore, Maryland	

13. FATHER'S NAME: Henry Charles Stettes

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Pattgiesen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		Mrs. Helen M.Stettes, 3014 Hamilton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of Prostate	11 mos.
	DUE TO	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C) Essential Hypertension	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Nyamed	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 19 48 *to* Feb. 20 19 49 *that I last saw the deceased alive on* Feb 20 19 49, *and that death occurred at* 4:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. H. Grenzer M. D.	1402 E. Lanvale St.	2-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-24-49	Holy Redeemr	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR / ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

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Dr. Hayward
13 E. Eager Street

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

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G71823

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): IDA C. RICE

2. DATE OF DEATH: Feb. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Eager Nursing Home, 4700 Harford Road

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2104 Lake Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	Feb. 8, 1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Maryland	

13. FATHER'S NAME: Frederick Rice

14. MOTHER'S MAIDEN NAME: Elizabeth A. Wadekemper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mr. Thomas J. Rice,	2104 Lake Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho-pneumonia (Terminal) — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO Arteriosclerosis cause of death

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chr. Interstitial Nephritis, uremia
DUE TO 2 — (2) — (2) — (2)

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catherine Wilhelm

2. DATE OF DEATH: Feb. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged Poor
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 24 N. Glover St 6-0-V

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W.	S.	March 2 1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto Md	

13. FATHER'S NAME: Conrad Whilhelm

14. MOTHER'S MAIDEN NAME: Catherine Schuster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Sister Superior	1201 Valley St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Acute Dilatation of Heart	1 day
DUE TO		
(B)	Chronic Myocarditis	8 yrs
DUE TO		
(C)	Arterio-Sclerosis	10 yrs

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 1 *, 19*49*, to* Feb 22 *, 19*49*, that I last saw the deceased alive on* Feb 21 *, 19*49*, and that death occurred at* 5 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. Gill Hall M.D. M. D.	1631 E. North Ave	Feb 22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/25/49	Holy Redeemer	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Leonard J. Peake	5305 Stanford

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Dr. Harbold

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71825

BIRTH NO.

1. NAME OF DECEASED (Type or Print): THERESA MARIE GERLACH

2. DATE OF DEATH: Feb. 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gardenville Nursing Home, 5440 Belair Road

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3132 Stafford Street 20-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	1871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Springfield, Mass.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Schwartzman

14. MOTHER'S MAIDEN NAME: Anna Marie Dumrauf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT ADDRESS: Mrs. Anna Auck, 2141 Harford Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast (right) — INTERVAL BETWEEN ONSET AND DEATH: 10 years

DUE TO

with metastasis to lungs + abdomen

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic myocarditis — ?

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JAN. 5, 1949 *to* Feb 19, 1949, *that I last saw the deceased alive on* Feb 19, 1949 *and that death occurred at* 10:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: H. V. Harbold M. D.

23B. ADDRESS: 4706 Harford Road

23C. DATE SIGNED: 2-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-23-49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 23 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road.

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Charles Bowers (BOWERS)

2. DATE OF DEATH February 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto City

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

D. STREET ADDRESS (If rural, give location) 2012 Bramblewood Rd.

c. Length of stay in Baltimore: Yrs. 1 Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	married	6-28-20	28	7	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Boston		Mass.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Bowers	Irene Page

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
				JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Homologous Serum Jaundice with acute yellow atrophy — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-20, 1949 *to* 2-21, 1949, *that I last saw the deceased alive on* 2-21, 1949, *and that death occurred at* 7:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	JOHNS HOPKINS HOSPITAL	FEB 21 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	2/24/49	Woodlawn Mem	Clinton Mass

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Philip Herwig Sons	2029 Orleans St

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 444 G71827

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES WOODS

2. DATE OF DEATH: February 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bar-Wil-Mar Nursing Home
1317 Madison Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 704 Hanover Street 22-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	colored	Widowed	12/27/1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
		North Carolina	

13. FATHER'S NAME: Alexander Woods

14. MOTHER'S MAIDEN NAME: Alice ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 212-18-3198

17. INFORMANT: Leola Woods Taylor — ADDRESS: Bellevue, N. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio-vascular-renal disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George L. Merrill M.D.

23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Feb. 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/23/49	Mt. Zion	Lakeland, Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 23 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Charles A. Rice — ADDRESS: 661 W. Baltimore St.

VS 151

1310

7718.8

BALTIMORE CITY HEALTH DEPARTMENT 442 7718.8

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN W. FITZPATRICK

2. DATE OF DEATH: 2/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 710 Pacific street
c. Length of stay in Baltimore: 76 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 710 Pacific street 13-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	white	married	Jan. 13, 1865	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Custodian- Court	House Balto. City	England	U.S.A.

13. FATHER'S NAME: Unknown Fitzpatrick

14 MOTHER'S MAIDEN NAME: Ellen Pine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): -----
(If yes, give war or dates of service):

16 SOCIAL SECURITY NO.: ----

17 INFORMANT: Mrs. Harry B. White ADDRESS: 710 Pacific st.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardio-Renal-Vascular Disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 14, 1949 *to* Feb 21, 1949 *that I last saw the deceased alive on* Feb 21, 1949 *and that death occurred at* 4.45 p. m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
J. H. Wilson M.D.	617 N. 40th St	Feb 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/24/49	Most Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Entering for Williams M.D.	Chas. G. Evans & Son, Inc.	118 W. Mt. Royal ave.

VS 150

131a

G71829

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54

G71829 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John H. Armstead

2. DATE OF DEATH: Feb. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon-Wit-Mar Apartments 1317 Madison Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 737 Dolphin St.

5. SEX	6 COLOR or RACE	7 SINGLE MARRIED WIDOWED DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	Colored	Widower	Sept. 12, 1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	U. S. A

13. FATHER'S NAME: Joseph Armstead

14 MOTHER'S MAIDEN NAME: Jane Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
No			Mr. John W. Armstead	737 Dolphin St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (a)	Chronic Nephritis	?
DUE TO (b)	Prostatism (Hypertrophied Prostate)	?
DUE TO (c)		?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Arteriosclerosis	?

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb 27, 1948 *to* Feb 20, 1949 *that I last saw the deceased alive on* Feb 20, 1949, *and that death occurred at* 10 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
M. D.	86 Stanley Ave	2-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2-22-49	Mt. Auburn Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Deputy for Registrar, Md.	Mrs. Frances A Hemsley	578 W. Biddle St

VS 150

1318

G71830 ✓ G71830

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 334

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Eugene Conquest

2. DATE OF DEATH: 20 Feb. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1422 Mc Culloh St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1422 McDulloh St. 1-4-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 hours: Hours, Min.
Male	Colored		Aug. 2, 1895	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	U. S. A

13. FATHER'S NAME: Henry Conquest

14. MOTHER'S MAIDEN NAME: Mary Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No.	213-01-7287	Mrs. Lottie Conquest	1422 McCulloh St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Accident
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Wm. H. Kammer, Jr. M.D.		21 Feb. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-23-49	Mt. Auburn Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Mrs. Frances A. Hemsley	578 W. Biddle St

VS 151

83a

G718.51 ✓ E974.° G718.51

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

W 99.5

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH GRUNDY
2. DATE OF DEATH: February 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 210 Corvin Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Widowed	2/8/1898	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	U.S.A.

13. FATHER'S NAME: Thomas Gundy
14. MOTHER'S MAIDEN NAME: Henretta Forther

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT / ADDRESS: Henry Gundy 127 N. BondSt.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Asphyxiation	
DUE TO	hanging	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 210 Colbourne Street
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: February 18, 1949 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hanged self by belt

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 2-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/23/1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn Md.

(24E. RECEIVED BY REGISTRAR) FEB 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR / ADDRESS: Elroy O. Wilson 1000 Brantly Ave.

VS 151

164a

6718.12 26785 ✓ 443 6718.12

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lula Hall

2. DATE OF DEATH: 2-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 3 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1321 E. Fayette St. 5-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years / Under 1 Year: Months, Days / Under 24 Hours: Hours, Min.)
F	C	W	March 15 1895	53

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Fairfield Sc	U.S.A.

13. FATHER'S NAME: Joe Thompson (D)

14. MOTHER'S MAIDEN NAME: Unemployed UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Amos Thompson 1105 Asquith St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		(INTERVAL BETWEEN ONSET AND DEATH)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Congestive Heart Failure	2 Weeks
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Hypertensive Arteriosclerotic Cardiovascular Disease	1 Year
DUE TO		
(C)	Cerebral Vascular Accident	2 Weeks
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-11-49, 19__, *to* 2-20-49, 19__, *that I last saw the deceased alive on* 2-20-49, 19__ *and that death occurred at* 6.55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. A. Rogers M. D.	B.C.H.	2-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/23/1949	Mt. Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Elroy O. Wilson 1000 Brantly Ave.

VS 150

937

G718.53 G718.53

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. BC.Y-7760 Registered No. N-971.9

1. NAME OF DECEASED (Type or Print): WILLIAM KOLODNY

2. DATE OF DEATH: 2/22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland SYDENHAM HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SYDENHAM Hospital

c. Length of stay in Baltimore: 5 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE MD. B. COUNTY BALTO.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ESSEX, BALTO.

D. STREET ADDRESS (If rural, give location): 21A CEDAR DRIVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	SINGLE	JUNE 6, 1943	5 YRS.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CHILD		BALTO. MD.	

13. FATHER'S NAME: A. Lewis KOLODNY

14. MOTHER'S MAIDEN NAME: MILDRED FISKE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
NO			FATHER	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL DAMAGE

DUE TO

(B) DEMEROL POISONING — 5 HRS.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY

Carl L Rogan M. D.

CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
accident	home	21A Cedar Drive, Essex, Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21F. HOW DID INJURY OCCUR?
2-21-49 approx. 9.00p m.		Ingestion of demerol

22. *I hereby certify that I attended the deceased from* 2/21, 1949 *to* 2/22, 1949, *that I last saw the deceased alive on* 2/22, 1949, *and that death occurred at* 215 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Carl L. Rogan M. D.	Sydenham Hospital	2/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 23, 1949	Arlington Cemetery	Rogers Ave Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Sol Levinson & Bros	1124 W North Ave

VS 150

179x

G718.54

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

492 Registered No.

G718.54

BIRTH NO.

1. NAME OF DECEASED (Type or Print) OSCAR DALE CAMPBELL

2. DATE OF DEATH 2/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1735 E. Lanvale Street

c. Length of stay in Baltimore — Yrs. Life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1735 E. Lanvale Street 8-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Feb.14, 1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Bank Alexander Brown	Baltimore, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nelson Campbell	Rebecka ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	212-09-4209	Mrs. Lillie M. Campbell 1735 E. Lanvale Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis/Insufficiency	1 Day
DUE TO (B)	Virus Pneumonia	3 Days
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 17, 1949, *to* Feb 20, 1949, *that I last saw the deceased alive on* Feb 20, 1949, *and that death occurred at* 9:45A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lee M. Zimmerman M.D.	2050 Harford Rd	2/23, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/23/49	Loudon Park cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 23 1949	[illegible] for Millicent, M.D.	HENRY SANDER & SONS, INC.

VS 150 BALTIMORE - 13, MARYLAND

94a

G718:5

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

190 Bischof

G718:5

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) LEONARD E. BISCHOF	2. DATE OF DEATH Feb. 21, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2907 Walbrook Ave.	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D STREET ADDRESS (If rural, give location) 4131 Norfolk Ave.
c. Length of stay in Baltimore Yrs. Mos. Days	

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
male	white	married	Apr. 19, 1903	45 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman-Pipe Fitters	Bethlehem Steel Co.	Rock Port, Missouri	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William A. Bischof	Louise Zieke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no			Mrs. Elizabeth A. Bischof	4131 Norfolk Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 14 ds.

DUE TO

(B) Coronary Embolus — 15 Min.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-21-49 *to* ——— 19—, *that I last saw the deceased alive on* 2-21 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Howard K. Warren M. D.	2604 Garrison Blvd	2-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/24/49	Cathedral Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	D. J. TICKNER & SONS	Balto., Md.

VS 150

108

G71836

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

2/16 G71836 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sophie McLeod

2. DATE OF DEATH: 2-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq. Hosp.

c. Length of stay in Baltimore: 18 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt.
D. STREET ADDRESS (If rural, give location): 822 Hollins St. 18 3

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 3-24-1891
9. AGE (In years last birthday): 57 (If Under 1 Year: Months 11, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Wil. Del.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Daugherty.
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ✓
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mary Margaret McLeod ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 20 yr
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-16 1949 *to* 2-21 1949 *that I last saw the deceased alive on* 2-21 1949, *and that death occurred at* 11 30 m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. J. Laham M. D.
23B. ADDRESS: Franklin Sq. Hosp.
23C. DATE SIGNED: 2-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2 Mar 49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Nat'l Cem.
24D. LOCATION (City, town, or county) (State): 5501 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: FEB 23 1949
REGISTRAR'S SIGNATURE: H. Errington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan ADDRESS: 201 Hollins St.

VS 150

95C

G718.57 ✓ ✓ G718.57

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 427

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SUSIE BROWN

2. DATE OF DEATH: February 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. 5 Mos. 0 Days 1

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 129 North Central Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	colored	Married	1891	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 10B. KIND OF BUSINESS OR INDUSTRY: Labor

11. BIRTHPLACE (State or foreign country): Dorchester County

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Campbell

14. MOTHER'S MAIDEN NAME: Annie Campbell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Royer M.D

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Feb. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb 24 1949

24C. NAME OF CEMETERY OR CREMATORY: Cross Road

24D. LOCATION (City, town, or county) (State): Dorchester County

DATE RECEIVED BY LOCAL REGISTRAR: 2-23-1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Lewis H Boyden

ADDRESS: Cambridge 201 Washington Street

VS 151

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57-0

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Levy

2. DATE OF DEATH 2 - 18- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Crownsville
D. STREET ADDRESS (If rural, give location) no other address Crownsville State Hospitals

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 1 Day: Hours / Min.
M	C	?	?	63 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		?	

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Records Baltc. City Hospitals	4940 Eastern Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration- Pneumonia

DUE TO Bowel Obstruction due to prolapsed Colestomy.

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2- 11-, 1949, *to* 2- 18-, 1949 *that I last saw the deceased alive on* 2- 18-, 1949, *and that death occurred at* 5 00 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. L. Cosgrove M. D.	4940 Eastern Ave.	2-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	FEB 21 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

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G718.9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G718.9

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jesse Anthony Noble

2. DATE OF DEATH: February 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR (If not in hospital or institution, give street address or location): St. Joseph's

c. Length of stay in Baltimore: 27 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 919 Rutland Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	Colored	Divorced	May 22, 1899	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Texas	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma of ~~Lung~~ brain

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of Lung

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(INTERVAL BETWEEN ONSET AND DEATH)

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 28, 1948 *, to* Feb. 20, *, 1949, that I last saw the deceased alive on* Feb. 20, *, 1949, and that death occurred at* 5 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
William A. Rodgers, M. D.	1400 N. Caroline St.	Feb. 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-24-49	Mt Auburn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Testing for Williams, MD	William Reese II	1082 Washington St. Balto. Md.

VS 150

47D

G71840

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71840

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edmund Urbanski

2. DATE OF DEATH: Feb. 21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 515 S. Montford Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
STATE
B. COUNTY
515 S Montford Ave
C. CITY OR TOWN (If outside corporate limits, write RAL and give township)
Baltimore Md
D. STREET ADDRESS (If rural, give location)
515 S Montford Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	Nov. 29 - 97	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	11A. CITIZEN OF WHAT COUNTRY?
Chief Steward		Baltimore	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wladyslaw Urbanski	Elizabeth Hedrich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		096125142	Amelia Urbanski	515 S Montford Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B) DUE TO: Cardio Vascular Disease — 1 year
(C) Hypertensive.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give street location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 16 1949 *to* Feb 21 1949, *that I last saw the deceased alive on* Feb 21 1949, *and that death occurred at* 7:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Rev. J. Zamarski M. D.	2211 Carlton Ave	Feb 22 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)
Burial	Feb 25/49	Holy Cross	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Fred W. Orzazewski	1930 Eastern Ave

VS 150

931

G71841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71841

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Anna Rosenthal

2. DATE OF DEATH: 2-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Women's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5842 Pembridge Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, (WIDOWED), DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If years, last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W		[illegible]	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Russia	

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mrs Kitty Baum	4100 Pembridge Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) 1) Heart failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart disease

DUE TO 2 Hypertension

(C) 3 Pulmonary Edema

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-20-49, 19__, *to* 2-22-49, 19__, *that I last saw the deceased alive on* 2-22-49, 19__, *and that death occurred at* 9:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. C. Decker, M.D.	Women's Hospital	2-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-23-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Place

VS 150

93D

G71842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71842

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ABE GERSHEN

2. DATE OF DEATH: 2-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2301 Edgemont Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2301 Edgemont Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	married		69		

10A. USUAL OCCUPATION (Give kind of work done during most working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Poland	

13. FATHER'S NAME: Louis

14. MOTHER'S MAIDEN NAME: Nancy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Freda Gershen	2301 Edgemont Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis (2nd attack) — INTERVAL BETWEEN ONSET AND DEATH: Dec 10, 1st attack

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension - Cardiac Hypertrophy arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June '48	Acute Cholecystitis Pancreatitis Chronic cholecystitis	YES ☐ NO ☑

21. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 6, 1948 *to* 2-23, 1949, *that I last saw the deceased alive on* 2/23, 1949, *and that death occurred at* 7:15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Theodore Cooper M.D.	2301 Entaw Place	2/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-20-49	Hebrew Young Mens	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Entaw Pl

VS 150

95c

G71843 126923

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

593 G71843 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Cecil Ward

2. DATE OF DEATH: 2- 20- 49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 23 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 223 N. Calhoun St.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	C	M	June 1-1900	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		VA.	

13. FATHER'S NAME: Giles Ward

14. MOTHER'S MAIDEN NAME: Nannie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records Dept. City Hospitals	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	1 week
DUE TO (B)	Glomerulonephritis	3 yrs.
DUE TO (C)		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Congestive Heart Failure	1 Mo.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2- 15- , 1949 *to* 2- 20- , 1949, *that I last saw the deceased alive on* 2- 20-, 1949, *and that death occurred at* 3 00A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. A. Wolz M. D.	B.C.H. 4940 Eastern Ave.	2- 20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	2/25/1949	Pinero Cem.	Gloucester Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Mrs Katie R. Williams	Records

VS 150

130

G71844

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71844

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Nettie Smith

2. DATE OF DEATH 2-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 665 Sarah Ann St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 665 Sarah Ann St. 4-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
Female	Col.	Widow	Aug 29 1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Eastern Shore Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Will Floyd	Henny Warton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		Velmar Taggins	665 Sarah Ann St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO Hypertensive Cardio Vascular renal disease — INTERVAL BETWEEN ONSET AND DEATH unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) Uremia — 4 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/6 19 49 *to* 2/21 19 49 *that I last saw the deceased alive on* 2/21 19 49 *and that death occurred at* 4:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William Dasser M. D.	213 Gough St	2/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-24-49	M.M.P. Cemetery	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Miss Katie R. Williams	922 N. Schroeder St.

VS 150

131a

G718:5

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1544 Registered No. G718:5

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Geraldine Kelly
2. DATE OF DEATH: Feb. 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Hosp. #2
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore October 21, 1948 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: South Africa
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Port Elizabeth
D. STREET ADDRESS (If rural, give location): 196 Main Road - Walmer

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	single	9-27-45	3 years		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		S. Africa	S. Africa

13. FATHER'S NAME: Edmund Kelly
14. MOTHER'S MAIDEN NAME: Dora Thornton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSP...

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation — (Interval between onset and death): 4 mons.
DUE TO Cong. Cardiac anomaly - Pulmonary atresia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Acute glomerular nephritis — 6 wks

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-29-49	Pulmonary atresia	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/1/49 to 2/22, 1949 *that I last saw the deceased alive on* 2/21, 1949, *and that death occurred at* 2:35 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herman Clark Spencer M. D.	JOHNS HOPKINS HOSPITAL	2-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/23/49	Holy Redeemer Cemetery	4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR / ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street

VS 150

157E

G71846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71846

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): William Garratt Griffiths

2. DATE OF DEATH: Feb. 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 441 N. East Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 441 N. East Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	Sept. 8, 1901	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Water Dept. City		Baltimore, Md.	U.S.

13. FATHER'S NAME: George H. Griffiths

14. MOTHER'S MAIDEN NAME: Louise Helen McDorman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Evelyn Giffiths - 441 N. East Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary arteriosclerosis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-1-46, *to* 2-21-49, *that I last saw the deceased alive on* 2-21-1949, *and that death occurred at* 4:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John J Gould M. D.	144 East ave	2-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 24, 1949	Druid Ridge Cemetery	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

94a

AB-125533
7187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

7187 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Banks

2. DATE OF DEATH: Feb. 22-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Yrs. Likrs Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 5612 Swallow Lane 24 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Col.	Married	Nov. 15- 1913	35		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Major Smith
14. MOTHER'S MAIDEN NAME: Sarah or Sara Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT 4940 Eastern Ave. ADDRESS: Records-Baltimore City Hospitals

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	3 wks.
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Carcinoma of Cervix	8 Mos.
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 23- , 1948 *to* Feb. 22- , 1949, *that I last saw the deceased alive on* Feb. 22- 1949, *and that death occurred at* 11.40 m. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B ADDRESS: Baltimore City Hospitals
23C DATE SIGNED: Feb. 22-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 25/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D LOCATION (City, town, or county) (State): A A County Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 23 1949
REGISTRAR'S SIGNATURE: Acting for Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Cath A Elliott & Dgt
ADDRESS: 1129 N. Carrollton St

VS 150

48a

G71848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

590

G71848

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Jane Eleanor Jackson

2. DATE OF DEATH: 2-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Bon Secours Hosp
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours
C. Length of stay in Baltimore: Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville Manor
D. STREET ADDRESS (If rural, give location): 5931 Cecil Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	5-5-17	31	9 / 16	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Md	U.S.

13. FATHER'S NAME: Arthur Phillip Harple

14. MOTHER'S MAIDEN NAME: Myrtle M. Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	169-16-5191	Wilbur Jr. Jackson	5931 Cecil Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute Congestive Heart Failure	24 hrs.
DUE TO (B)	Hypertension Arteriosclerosis	7 days
DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 2-18-1949 to 2-21-1949 that I last saw the deceased alive on 2-21-1949, and that death occurred at 11 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard C. Hayden M.D.	Bon Secours Hosp	2-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 25. 1949	London Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	[illegible]	Wm. Wm. John W. Teufel Son	5311 Edmondson Ave.

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CERTIFICATE CORRECTED 3-4-49 ✓ E903.5

G71849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. N.E54.0

G71849

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MILDRED ROGERS

2. DATE OF DEATH February 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
C. Length of stay in Baltimore LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 610 Scott Street 21-C ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White		MAY 16 (~~1902~~) 1902	46 (~~47~~)	9	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	OWN HOME	BALTIMORE MD.	

13. FATHER'S NAME JOHN GERBIG

14. MOTHER'S MAIDEN NAME CORA DEAVER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	No	No	EDGAR OSTENDORF	841 WOODWARD ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural hemorrhage (bilateral)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Front of 784 Washington Blvd 21/1

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) February 21, 1949 p m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Fell to sidewalk (Dang)

22. *I certify that I took charge of the remains described above, held an* Partial Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE Paul Reyer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED 2-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE 2-26-49

24C. NAME OF CEMETERY OR CREMATORY LOUDEN PARK

24D. LOCATION (City, town, or county) (State) BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR FEB 23 1949

REGISTRAR'S SIGNATURE Lillian Williams, M.D.

25. FUNERAL DIRECTOR Joseph T. Ambrose ADDRESS 1328 Lafayette Avenue

VS 151

186a

G71850 BALTIMORE CITY HEALTH DEPARTMENT G71850

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FREDERICK JOHNSON

2. DATE OF DEATH February 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
617 S. Ellwood Avenue

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 617 S. Ellwood Avenue 1-22

5. SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If under 1 Year: Months Days	If under 24 hours: Hours Min.
Male	white	Widowed	Aug. 15, 1895	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Chauffeur		Maryland	

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Unknown	Catherine Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
Yes	World War I		John M. Quinn	617 S. Ellwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L Royer M.D | 23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED Feb. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/24/49	Baltimore National	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	Lilly & Zeiler, Inc.	Baltimore Md.

VS 151

94a

G71851 BALTIMORE CITY HEALTH DEPARTMENT 290.0 G71851

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John Rice — John Edward Rice
2. DATE OF DEATH February 22, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital Balt. Md
C. Length of stay in Baltimore 65 years (Yrs. Mon. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1317 Weldon Avenue 13 01
5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH February 24, 1882
9. AGE (In years last birthday) 66 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Decorator
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore Co., Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John A. Rice
14. MOTHER'S MAIDEN NAME Margaret J. Baublitz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 219-01-9909
17. INFORMANT Mrs. Pearl Ensor Rice ADDRESS 1317 Weldon Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) (Pulmonary) Death due to
DUE TO (B) Massive Atelectasis of Rt lung.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (C) Pernicious Anemia, Cord changes & general debility with bed sores; loss of bowel, etc

INTERVAL BETWEEN ONSET AND DEATH (apparently about 4-5 yrs.)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) None
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None m.
21E. INJURY OCCURRED WHILE AT WORK ☐ None NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? None

22. *I hereby certify that I attended the deceased from* 2/14, 1949 *to* 2/22, 1949 *that I last saw the deceased alive on* 2/22, 1949 *and that death occurred at* 7 15/Am., *from the causes and on the date stated above.*

23A. SIGNATURE H. S. Pratt, Jr M.D.
23B. ADDRESS University Hosp. Balt Md
23C. DATE SIGNED 2/22/49
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Feb. 25, 1949
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge
24D. LOCATION (City, town, or county) Pikesville, Maryland (State)
DATE RECEIVED BY LOCAL REGISTRAR FEB 23 1949
REGISTRAR'S SIGNATURE Hunter for Williams, M.D.
25. FUNERAL DIRECTOR Burgee Funeral Home ADDRESS 3631 Falls Road

73a

E 890.0 ✓ E 890.0 G71852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V-968.0

BIRTH NO. G71852 Registered No.

1. NAME OF DECEASED (Type or Print): Steven Edward Marcinko
2. DATE OF DEATH: Feb 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
111 S. Ann Street
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto Md.
D. STREET ADDRESS (If rural, give location): 111 S. Ann Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	married	aug 12 1907	41	6	8

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stevedore	Longshoreman	Baltimore Md.	

13. FATHER'S NAME: Paul Marcinko
14. MOTHER'S MAIDEN NAME: Magdalena Kwiatkowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	World War 2	216-01-2027	Mrs Mary Marcinko	1810 Vaught St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asp Inspiration due to Carbon
DUE TO
(B) Monoxide Poisoning

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	111 S Ann St

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Feb 20 1949 - 11A m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Open burner on Gas Stove Violet

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, ~~suicide~~ ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
William J Helpich M.D	☒	2/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Feb 24/49	Holy Rosary (em	Balto. County

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 22 1949	Harrington W. Wilbelmy	401 S. Chester	Street

VS 151

John M. Weber 1782

CERTIFICATE CORRECTED 3-1-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G718:53 330 Registered No. G718:53

1. NAME OF DECEASED (Type or Print): ERWIN R. Zechman (Zechmann) — 2. DATE OF DEATH: 2-23-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give): 1327 Clifton (Oliver) Rd

5 SEX	6 COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	1-5-06	42	7 / 18	

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Foreman	Steel plant	Penna.	USA

13. FATHER'S NAME: William Zechman (Zechmann)

14. MOTHER'S MAIDEN NAME: Jennie Ruppert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 213-07-3478

17. INFORMANT: Susan Zechman (wife) ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Subarachnoid Hemorrhage	5 days
	DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST	(B)	? Hypertension	Several years
	DUE TO		
	(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		Perforated Stomach (Found at Autopsy) Etiology Unknown	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-18-, 1949, *to* 2-23-, 1949, *that I last saw the deceased alive on* 2-23-, 1949, *and that death occurred at* 3:45 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
A. R. Judd M. D.	Mercy Hospital	2-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
BURIAL	2-26-49	MORELAND MEMORIAL	BALTO. CO.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Washington Williams, M.D.	H.W. JENKINS & SONS CO.	4905 YORK RD. BALTO. 12, MD.

83a

G71854 ✓X E976.0 G71854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1-853

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NATHANIEL MOXLEY

2. DATE OF DEATH February 23, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland B COUNTY Harford
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Churchville
D STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	1899	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10B. KIND OF BUSINESS OR INDUSTRY Dairy

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME John Moxley

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Mrs Nathaniel Moxley ADDRESS Bel Air Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet Wound of Brain — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Churchville, Harford Co., Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) February 18, 1949 ? m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Partial autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE Earl L Riggin M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED 2-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Feb 26 1949

24C. NAME OF CEMETERY OR CREMATORY Mt Zion Cem

24D. LOCATION (City, town, or county) (State) Harford Co Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 23 1949

REGISTRAR'S SIGNATURE Thomas Williams, M.D.

25. FUNERAL DIRECTOR H. S. Bailey ADDRESS Darlington, Md.

VS 151

164 c

BIRTH NO. G718:5

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71855

1. NAME OF DECEASED (Type or Print): Delia O'Keefe

2. DATE OF DEATH: Feb. 21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3502 Clifton Avenue

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3502 Clifton Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
Female	White	Single	?	about 80 Yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Baltimore, Md.	

13. FATHER'S NAME: Edward O'Keefe

14. MOTHER'S MAIDEN NAME: Bridget Walsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs. Fred A. Neville	125 Augusta Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pernicious Anemia	
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)	Chronic Myocarditis.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 17, 1949 *to* Feb 21, 1949, *that I last saw the deceased alive on* Feb 20, 1949, *and that death occurred at* 4:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. H. Butterman M. D.	2324 Reisterstown Rd	2/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/24/49	Cathedral Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 23 1949	Huntington Williams, M.D.	H. W. Mears & Son	805 N. Calvert St.

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G718:56 ✓ 260 G718:56

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Lilian W. Dural

2. DATE OF DEATH February 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Colonial Nursing Home 4506 Sorrento Road.

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3006 Edmondson Ave 16-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Single	Apr. 28, 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher (Art.)	Public Schools.	Baltimore	

13. FATHER'S NAME William A. Dural.

14. MOTHER'S MAIDEN NAME Fannie Musselman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Mrs. W. Buckman ADDRESS 1900 Griffith Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Diabetic Coma — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
ANTECEDENT CAUSES
(B) Diabetes Mellitus — ?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute Pharyngitis, Cerebral Arteriosclerosis

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1948 *to* Feb, 1949, *that I last saw the deceased alive on* 22 Feb, 1949, *and that death occurred at* 8:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Jay M. Zimmerman M. D. | 23B. ADDRESS 2858 Harford Rd. | 23C. DATE SIGNED 23 Feb. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 24/49	Druid Ridge	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 24 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Loring Byers ADDRESS 5005 Old Frederick Rd

VS 150

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G718:57 Hospital

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G718:57

BIRTH NO. Disposal 776 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Long

2. DATE OF DEATH: 2-14-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Hosp. H.L.H. Path

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B COUNTY a a Co.
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Woodlawn Beach
D STREET ADDRESS (If rural, give location)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		2-13-49			27

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Hugh Long

14. MOTHER'S MAIDEN NAME: Frances Long

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-13-, 1949 *to* 2-14-, 1949, *that I last saw the deceased alive on* 2/14, 1949 *and that death occurred at* 9:30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Hop Burial	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 24 1949	Huntington Williams, MD		

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G71858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71858

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARGARET HALLER

2. DATE OF DEATH: Feb. 23rd, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3407 Keene Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 3407 Keene Ave. 27-44

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
female	white	widowed	March 15, 1856	92	11 / 8	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Unknown	

13. FATHER'S NAME: Hubner

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
		Mr. William Haller	2934 E. Monument St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 11 days

DUE TO

(B) Pulmonary Edema — 11 days

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
none		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no		none

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 12 *19*49, *to* Feb 23rd *19*49, *that I last saw the deceased alive on* Feb 22 *19*49, *and that death occurred at* 8 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. K. Leady M. D.	5106 Harford Road	3/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
burial	2/26/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 24 1949	Huntington Williams, M.D.	Lassahn Funeral Home	7401 Belair Rd.

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G71859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

G71859

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis Richmond

2. DATE OF DEATH: 2-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 2308 Braddish Ave 15-47

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1868
9. AGE (In years last birthday): 80 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired tailor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Richmond
14. MOTHER'S MAIDEN NAME: Janet

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Louis Richmond ADDRESS: 2308 Braddish Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia pericarditis — Interval between onset and death: 2wks

DUE TO

(B) Uremia — 7wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Carcinoma of the bladder with metastasis — 4yrs

I

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1945
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of bladder
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-18, 1949 *to* 2-23, 1949 *that I last saw the deceased alive on* 2-23, 1949, *and that death occurred at* 11:50 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: Richmond MD M. D.
23B. ADDRESS: Church Home + Hospital
23C. DATE SIGNED: 2-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-24-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis
ADDRESS: 2100 Eutaw Pl

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G71860 G71860

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

260 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. LOUISE MELVIN

2. DATE OF DEATH: 22 FEB 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE # 11
D. STREET ADDRESS (If rural, give location): 2959 KESWICK RD. 1305

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GEN. HOSP.

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	MARRIED	24AUG 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BALTIMORE COUNTY

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: CHARLES CUDDY

14. MOTHER'S MAIDEN NAME: ANNA HEISSE.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: HUSBAND - ALBERT MELVIN ADDRESS SAME - ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DIABETIC ACIDOSIS	COMA 18 HOURS
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) DIABETES MELLITUS, UNCONTROLED	7 YRS 1 MONTH?
	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒ REFUSED

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give [illegible])

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 21 FEB, 1949 *to* 22 FEB, 1949 *that I last saw the deceased alive on* 22 FEB 1949, *and that death occurred at* 5 30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Donald F. Engeland M. D.

23B. ADDRESS: MARYLAND GEN. HOSP

23C. DATE SIGNED: 22 FEB 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb 24/49

24C. NAME OF CEMETERY OR CREMATORY: Wesley Chapel

24D. LOCATION (City, town, or county) (State): Balto Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Austin B. Donovan ADDRESS 3638 Poland ave.

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G71801 — 112 W. 25th St ✓ Ref 1960

BIRTH NO. G71801

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71801

1. NAME OF DECEASED (Type or Print): JANICE DEW

2. DATE OF DEATH: Feb. 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgewood Nursing Home, 6000 Bellona Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6000 Bellona Ave. 27-12

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Nov. 11, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		West Virginia	

13. FATHER'S NAME: (Unknown) Crim

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		None	Granger B. Menefee	2503 Lakeland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Erysipelas — INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO

(B) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH: indef

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 8, 1946 *to* Feb 22, 1949 *that I last saw the deceased alive on* Feb 22, 1949 *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. L. Richardson, M. D. — 23B. ADDRESS: 112 W. 25th St — 23C. DATE SIGNED: Feb 24, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/25/49	Cedar Hill	Brooklyn, A.A.County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 24 1949	Huntington Williams, M.D.	William Cook, Inc.,	1217 St. Paul St.

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G71862 G71862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

751 Registered No.

BIRTH NO. B.C.49-02813

1. NAME OF DECEASED (Type or Print): BABY GIRL WITHERS
2. DATE OF DEATH: 2-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: 12 (Years / Months / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: (Balto)
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 3111 Elm Ave. - 11

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 2-9-49
9. AGE (In years last birthday): 0 — If under 1 Year: Months 0, Days 12 — If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Mary Land
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: (not known)
14. MOTHER'S MAIDEN NAME: Evelyn Gertrude Withers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Eidman ADDRESS: 3111 Elm Ave Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Spina bifida Congenital
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): 0
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 0 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 7, 1949, to Feb 21, 1949, that I last saw the deceased alive on Feb 21, 1949, and that death occurred at 7.00 p m., from the causes and on the date stated above.

23A. SIGNATURE: Fred Grascobe Jr M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 2-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): cremation
24B. DATE: 2-23-49
24C. NAME OF CEMETERY OR CREMATORY: D M H
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 24 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25 FUNERAL DIRECTOR ADDRESS

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G71803 G71803

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1949 Registered No. 5

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Beatrice Washington
2. DATE OF DEATH: Feb 22, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland — Hosp. Halsted 4
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-1
D. STREET ADDRESS (If rural, give location): 519 N. Strieker St
C. Length of stay in Baltimore: 13 years (Yrs. Mos. Days)
6. SEX: Female
7. COLOR OR RACE: Colored
8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
9. DATE OF BIRTH: 5-16-14
10. AGE (In years last birthday): 34 yrs (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Lee Bradley
14. MOTHER'S MAIDEN NAME: Hannie Harvey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Unknown, possibly due to

DUE TO

(B) metastatic Cancer to Brain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Month Year
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-21 1949 to 2-22 1949, *that I last saw the deceased alive on* 2-22 1949, *and that death occurred at* 11 35 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: George G. Culbreth M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 2-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/27/49
24C. NAME OF CEMETERY OR CREMATORY: Weldon
24D. LOCATION (City, town, or county) (State): Weldon N C

DATE RECEIVED BY LOCAL REGISTRAR: FEB 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: William A Jackson 916 Penna Ave

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G71864

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71864

1. NAME OF DECEASED (Type or Print): Mattie Bradley

2. DATE OF DEATH: 2/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 917 Argyle Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 917 Argyle ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto City
D. STREET ADDRESS (If rural, give location) 917 Argyle ave 17-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colord		1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unemployed		Enfield N C	U. S. A.

13. FATHER'S NAME: Jim Bennett

14. MOTHER'S MAIDEN NAME: Polly Wade

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Minnie Thompson ADDRESS: 724 Wilmot Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intermediate Heart Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/23, 19 49, *to* 2/23, 19 49, *that I last saw the deceased alive on* 2/23, 19 49, *and that death occurred at* 8:05 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William M. Dorman M. D.	753 Gorsuch	2/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/28/49	Enfield #	Enfield N C.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 24 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: William A Jackson ADDRESS: 916 Penna Ave

VS 150

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G71865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 334

Registered No. G71865

BIRTH NO.

1. NAME OF DECEASED (Type or Print): OLIVER HARRIS

2. DATE OF DEATH: 2/21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1108 N. Stockton 16-1

5. SEX: M
6. COLOR OR RACE: N
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 10/5/1880
9. AGE (In years last birthday): 68
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Lily Harper ADDRESS: 1108 N. Stockton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/19 1949 *to* 2/21 1949 *that I last saw the deceased alive on* 2/21 1949 *and that death occurred at* 4 00 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. Preston Grant M.D.
23B. ADDRESS: 601 N. Carrollton
23C. DATE SIGNED: 2/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/24/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Geo. G. Nelson ADDRESS: 1303 Westwood Ave

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G71866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

BIRTH NO. G71866 Registered No.

1. NAME OF DECEASED (Type or Print): Joshua H Cromwell

2 DATE OF DEATH: 2/22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1639 Calhoun St

c. Length of stay in Baltimore: 27 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE: Md B. COUNTY: Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto

D. STREET ADDRESS (If rural, give location): 1639 Calhoun St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	C	Married	1/20-1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butler

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Harford Co Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joshua Cromwell

14. MOTHER'S MAIDEN NAME: Rosa Berry (Cromwell)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.

17. INFORMANT: Genevieve L Cromwell ADDRESS: 1639 Calhoun St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Apoplexy + Paralysis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/21/49 *to* 2/22/49, *that I last saw the deceased alive on* 2/22 19 49 *and that death occurred at* 2 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Bk R Belt M.D. | 23B. ADDRESS: 2139 Druid Hill Ave | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/25/49	Mt. Calvary	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR | ADDRESS: Geo. P. Kelly 1303 Pennsylvania Ave

VS 150

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G71867 — BALTIMORE CITY HEALTH DEPARTMENT — 120.1 — G71867

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE C. SPILLNER SR.

2. DATE OF DEATH: Feb 23. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6005 Sycamore Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): /
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 6005 Sycamore Road
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 27
D. STREET ADDRESS (If rural, give location): 6005 Sycamore Road

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Feb 21. 1891	58	0 / 7	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	Automotive	Baltimore Md.	

13. FATHER'S NAME: William F. Spillner

14. MOTHER'S MAIDEN NAME: Matilda U. Belt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	213-03-4228	Myrtle V. Spillner	6005 Sycamore Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* 2/22, 1949, *and that death occurred at* 1.5a *-m., from the causes and on the date stated above.*

23A. SIGNATURE: Thos F Doser M. D. | 23B. ADDRESS: 700 N. Clinton St | 23C. DATE SIGNED: 2/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 26. 1949	Loudon Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Mrs. Mae John W. Fowler & Son 5311 Edmondson Ave

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(Dr. Silberfeld
714 Preston St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 490 — 6718

BIRTH NO. B.C.49-09515

1. NAME OF DECEASED (Type or Print): MARY RITA GRAU

2. DATE OF DEATH: Feb. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 630 Cokesbury Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 630 Cokesbury Avenue 9 15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	May 5, 1948		9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
child		Baltimore, Maryland	

13. FATHER'S NAME: Frederick Grau

14. MOTHER'S MAIDEN NAME: Mary Rita Franz ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mrs. Mary R. Grau, 630 Cokesbury

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	pneumonia	3 days
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		over
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1948, *to* 23 Feb, 1949 *that I last saw the deceased alive on* 22 Feb, 1949, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. Silberfeld M. D.	714 E. Preston	24 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-25-49	Holy Redeemer	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 24 1949	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

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G71869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71869

BIRTH NO. B.C. 49088 ALLEN

1. NAME OF DECEASED (Type or Print) George Clautice

2. DATE OF DEATH 1/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sydenham Hosp.tal

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4212 Frankford Ave. 26 01

5. SEX	6. COLOR OR RACE	7. SINGLE MARRIED WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
male	White	Single	28 Sept. 1944	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child	none.	Maryland	

13. FATHER'S NAME: George Clautice

14. MOTHER'S MAIDEN NAME: Kathryn Shed

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Father -	4212 Frankford Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Tuberculous Meningitis	3 months
DUE TO (B)		
DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 1, 1949 *to* Jan 22, 1949, *that I last saw the deceased alive on* Jan 22, 1949, *and that death occurred at* 11:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Abner W. Allen M.D.	Sydenham Hosp.tal	2/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	1/26/49	Morgland Park	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 24 1949	Huntington Williams, M.D.	Leonard J. Luck	5305 Harford

VS 150

14

G718.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G718.0

BIRTH NO. BC 49-14696 057.7 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Edward J. Pellens
2. DATE OF DEATH: 2/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3102 Royston Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	White	single	July 15-1948	0	7	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto - Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Joseph Pellens
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Monahan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: father — ADDRESS: 3102 Royston

CAUSE OF DEATH

16. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) overwhelming toxicity

DUE TO

(B) diffuse pneumonia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pos. Waterhouse - Fredrickson Syndrome

MEDICAL CERTIFICATION

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 21 1949 *to* Feb. 22 1949 *that I last saw the deceased alive on* Feb. 22 1949 *and that death occurred at* 1:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: D. Schohler M. D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 2/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/24/49
24C. NAME OF CEMETERY OR CREMATORY: St. Stephens
24D. LOCATION (City, town, or county) (State): Brooklawn Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: L. J. Luck
ADDRESS: 5305 Harford

VS 150

6

G718'71 G718'71

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

Registered No.

1. NAME OF DECEASED (Type or Print): Anthony Dorosz

2. DATE OF DEATH: 2-23-'49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto.
D STREET ADDRESS (If rural, give location): 1627 Ceadox Ave 2-05

5. SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	M	June 17-1876	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Blacksmith		Poland	

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Dorosz	Albina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
	215-09-1141	Anastasia Dorosz	1627 Ceddox st

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intra cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-20-49 19 *, to* 2-23-1949 *that I last saw the deceased alive on* 2-23-1949 *, and that death occurred at* 8⁵⁵ P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
C. D. Thomas, Jr. M. D.	Mercy Hosp	2-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Feb. 26-49	Holy Cross	A. A. Co.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 24 1949	Huntington Williams, M.D.	Wm. S. Fialkowski	2007 Eastern Ave

VS 150

83a

G7187.2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G7187.2

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): ROBERTA LOUISE FRANCIS

2. DATE OF DEATH: Feb. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 623 Melville Ave.

C. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 623 Melville Ave. 9 - 2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	May 22, 1940	8 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
–		Baltimore, Md.	

13. FATHER'S NAME: Raymond L. Francis

14. MOTHER'S MAIDEN NAME: Marion Henderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
–		Mr. Raymond L. Francis	623 Melville Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia
DUE TO Fatal Nausea Vomiting
(B) Diarrhea
DUE TO Other Undiscovered
(C) Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 2 or 3 days
(B) 4 days
(C) 1 wk
II 1 wk or 10 days
4 wks

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 17, 1949 *to* Feb 23, 1949, *that I last saw the deceased alive on* Feb 21, 1949, *and that death occurred at* 3 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter C Anderson M. D.	3601 Shannon Drive	2-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/26/49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 24 1949	Investigator Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

35

AB-126028

G71873

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71873 Registered No.

193

1. NAME OF DECEASED (Type or Print): Thomas C. Johnson

2. DATE OF DEATH: Feb. 15-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 3days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): (Rural) Crownsville, Anna Arundel County
D. STREET ADDRESS (If rural, give location): Crownsville State Hospital

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Col.	Single		44?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Saloon	Balto, Md.	

13. FATHER'S NAME: Alonza Johnson

14. MOTHER'S MAIDEN NAME: Ida Coats

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-03-6788

17. INFORMANT: Records Baltimore City Hospitals ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Brain Tumor, Right Frontal Lobe — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-12-49 *to* 2-15-49, *that I last saw the deceased alive on* 2-15-49, *and that death occurred at* 5:15 m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. A. Rogers, M. D.

23B. ADDRESS: 4040 EASTERN AVENUE

23C. DATE SIGNED: Feb. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/24/49

24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery

24D. LOCATION (City, town, or county) (State): A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 24 1949

REGISTRAR'S SIGNATURE: [illegible] REGISTERED

25. FUNERAL DIRECTOR: Robert Williams

ADDRESS: 1515 McElderry St

VS 150

Huntington Williams, M.D.

54B

G71874 — BALTIMORE CITY HEALTH DEPARTMENT — G71874

CERTIFICATE OF DEATH

Registered No. 3532

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Perry Jr. - Krukzewski
2. DATE OF DEATH: Feb. 22 - 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland — John Hopkins Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 11
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 6-07
D. STREET ADDRESS (If rural, give location): 24 N. Lakewood ave
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Feb. 21 - 1911
9. AGE (In years last birthday): 38 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): L
10B. KIND OF BUSINESS OR INDUSTRY: L
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Perry Sr.
14. MOTHER'S MAIDEN NAME: Gertrude Budka
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John Perry Sr. ADDRESS: 24 N. Lakewood ave

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Acute Cardiac Dilatation, sudden	
DUE TO		
(B)	Enlarged Heart	5 yrs.
DUE TO		
(C)	Epilepsy	15 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. , 1928 *to* Feb. 22, 1949 *that I last saw the deceased alive on* Feb. 20, 1949 *and that death occurred at* 12:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: John V. Szczerbicki M.D.
23B. ADDRESS: 1802 Eastern Ave
23C. DATE SIGNED: 2-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/25/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 24 1949
REGISTRAR'S SIGNATURE: Curtis Williams M.D.
25. FUNERAL DIRECTOR: Wm. S. Fiallkowski ADDRESS: 2007 Eastern Ave

VS 150

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G71875

ES-117132

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

441

G71875

Registered No.

1. NAME OF DECEASED (Type or Print): Robert Powell

2. DATE OF DEATH: 2-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto.
D. STREET ADDRESS (If rural, give location): 313 S. Conkling St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Widow	Aug. 29, 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	U.S.

13. FATHER'S NAME: John Powell

14. MOTHER'S MAIDEN NAME: Susie Layfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		RECORDS*BALTO. CITY HOSP.	4940 EASTERN AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	1 mo.
DUE TO (B)	Arteriolarnephrosclerosis and Hydronephrosis	6 Mo.
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Broncho-pneumonia	1 Week

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 2-2 19 48, *to* 2-23 19 49, *that I last saw the deceased alive on* 2-23 19 49 *and that death occurred at* 2:40 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. L. Rogers M. D.	4940 EASTERN AVENUE	2-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 25-49	Mt Carmel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 24 1949	[illegible]	John G. Connelly	416 Eastern Ave Balto 24 Md.

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G71876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20. 1

Registered No. G71876

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Katherine Wilkinson

2. DATE OF DEATH Feb 22 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 113 N Belnord Ave 6-

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH March 23 1879

9. AGE (In years last birthday) 69. If under 1 Year: Months Days If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY Housework

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Ellenbourne

14. MOTHER'S MAIDEN NAME Elizabeth Bornbrom

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Samuel Wilkinson ADDRESS 1136 N Belnord Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

DUE TO

(B) Chronic Myocarditis — 10 years

DUE TO

(C) Cardio-Vascular Hypertensive Disease — 10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 10, 1939, *to* Feb 22, 1949, *that I last saw the deceased alive on* Feb 22, 1949, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Michael J. Dorsch M. D.

23B. ADDRESS 1 W. Oversea Ave.

23C. DATE SIGNED 2/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Feb 26 1949

24C. NAME OF CEMETERY OR CREMATORY Oak Lawn

24D. LOCATION (City, town, or county) (State) Loetrin Cir Road

DATE RECEIVED BY LOCAL REGISTRAR FEB 24 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR John C Mosen ADDRESS 3000 E Baltimore St

VS 150

937

G718.47 B.S.-126039

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G718.47 157 Registered No.

1. NAME OF DECEASED (Type or Print): Sterling Huff

2. DATE OF DEATH: 2-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 600½ E. 27½ St. 1-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married	[illegible]	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Ga.	U.S.

13. FATHER'S NAME: Isaac Brudslaw

14. MOTHER'S MAIDEN NAME: Cicero Huff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: RECORDS*BALTO. CITY HOSPITALS Eastern Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cancer of the Pancreas	6 weeks
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 1-13 , 19 49 , *to* 2-22- , 19 49 , *that I last saw the deceased alive on* 2-22- , 19 49 , *and that death occurred at* 11:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. L. Vogas M. D.		

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-26-49	Mt Calvary Cem	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 24 1949	Huntington Williams, M.D.	Rayner Sanders	469 1412 E Preston St

VS 150

G718.8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443

Registered No.

G718.8

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Josephine Pazdan

2. DATE OF DEATH: Feb 24 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 940 S. Kenwood Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 50 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D STREET ADDRESS (If rural, give location): 940 S. Kenwood Ave 1-4

5. SEX	6 COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
	Packing house	Poland	

13. FATHER'S NAME: unknown

14 MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT / ADDRESS
		Michael Pazdan 940 S Kenwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

DUE TO

(B) HYPERTENSIVE CARDIOVASCULAR DISEASE — 20 yrs.

DUE TO

(C) ARTERIOSCLEROSIS, GENERALIZED — 20 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 23, 1949 *to* Feb. 24, 1949 *that I last saw the deceased alive on* Feb. 24, 1949 *and that death occurred at* 2.45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Benjamin Hochstein M. D.	121 S. HIGHLAND AVE.	Feb. 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Feb. 28 1949	St. Stanislaus	Dundalk Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR / ADDRESS
FEB 24 1949	Huntington Williams, M.D.	John J. Duda 2029 Hudson St.

VS 150

9:D

G718.9 G718.9

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 43 4.1

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ROLAND C. BAKER
2. DATE OF DEATH January 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hosp.
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2219 Mount Holly Street 15-9

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
male	white	unknown	Unknown	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY unknown
11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 220-20-8918
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute congestive heart failure
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Earl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED January 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE Feb 23/49
24C. NAME OF CEMETERY OR CREMATORY Dulls National
24D. LOCATION (City, town, or county) (State) Dulls

DATE RECEIVED BY LOCAL REGISTRAR FEB 24 1949
REGISTRAR'S SIGNATURE Registrar of Williams, Md.
25. FUNERAL DIRECTOR Ellsworth Burnworth
ADDRESS 92 E 2911 Liberty Hwy

VS 151

G71830

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71830

BIRTH NO

1. NAME OF DECEASED (Type or Print) Dorothy Weaver

2. DATE OF DEATH 2/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp. INC.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE
B COUNTY 3313 O'Donnell ST
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md
D STREET ADDRESS (If rural, give location) 26-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	MARRIED	Sept 16, 1911	37		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Petitt	Margaret Bishop

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Generalized Carcinomatosis	
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Carcinoma Rectum	
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Abdomino-Perineal Resection	Ca Rectum	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 2, 1949 *to* Feb 22, 1949, *that I last saw the deceased alive on* Feb 22, 1949, *and that death occurred at* 11:59 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph L. Aponte M.D.	Mercy Hospital	2/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-25-49	Oak Lawn Cem	Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 24 1949	Huntington Williams, M.D.	John R. Mills Inc. 1435 E. Oliver St

VS 150

46D

G71881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 3698

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGIA FRAZIER

2. DATE OF DEATH: 2-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2427 Druid Hill Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2427 Druid Hill Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Married	Dec. 4-1902	46	1	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home wife	own home	Richmond, S.C. Baltimore, Md	American

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
J. S. Samuels	Charity Pope

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			John H. Frazier	2427 Druid Hill Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of intestines — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-17-1948, *to* 2-22-1949 *that I last saw the deceased alive on* 2-21-1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank A. Saunders M.D.	1029 W. Stratton St.	2-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/25/1949	Mt. Auburn	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 24 1949	Huntington Williams, M.D.	Jno. Chas. Holland	163 Druid Hill Ave.

VS 150

46 E

G71882

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

204.0

G71882 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Doris Baublits

2. DATE OF DEATH: 2/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. — Mos. — Days 11

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Millers
D. STREET ADDRESS (If rural, give location): —

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W.	single	March 15, 1947	1 —	23 mos.	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
child	child	maryland	U.S.

13. FATHER'S NAME: William M. Baublits

14. MOTHER'S MAIDEN NAME: Luella Baublits

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—	—	—	William M. Baublits	Millers, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemothorax, bilateral → INTERVAL BETWEEN ONSET AND DEATH
DUE TO Pulmonary congestion & edema → 1 day.

ANTECEDENT CAUSES

(B) Hemorrhagic diathesis → 13 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO Cardiac hypertrophy & failure → 1 day

(C) acute lymphoid leukemia → 13 days +
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Right ~~middle~~ lobular pneumonitis 17 days?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 2/14, 1949 *to* 2/23, 1949, *that I last saw the deceased alive on* 2/23, 1949 *and that death occurred at* — m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. Hartland, M D M. D.	University Hospital	2/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Feb. 26, 1949	Berkleysville	Berkleysville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 24 1949	Lemington Williams, M.D.	J. Jacob Hartlandia	New Freedom, Penna.

VS 150

74a

G71883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71883

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Richard Strow Hoddinott

2. DATE OF DEATH: 24 Feb. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital (DOA)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 825 N. Eutaw St 11-43

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 12/22/1902
9. AGE (In years last birthday): 46
If under 1 year: Months 2 Days 1
If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY: Banking
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Mark Hoddinott
14. MOTHER'S MAIDEN NAME: Isabella Strow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Albert S. Fox ADDRESS: Belvedere Hotel

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I (A) Pulmonary Tuberculosis, Far Advanced — Interval between onset and death: 1 yr.

DUE TO (B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 24 Feb. 49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial
24B. DATE: 2/26/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 151

13B

71884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 191

71884 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William A. Roberts

2 DATE OF DEATH 2/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Balto Gen Hosp

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D STREET ADDRESS (If rural, give location) 1008 Warwick ave 16 05

5. SEX	6. COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Married	Jan. 30th 1921	28	0 24	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Truck Driver	White-way Laundry	Stratford N C.	

13. FATHER'S NAME Arthur L. Roberts

14 MOTHER'S MAIDEN NAME Lydia Daniels

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT ADDRESS
		Mrs Wm Roberts 1008 Warwick Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Retroperitoneal Sarcoma	5 mos
DUE TO	(B) Neurosarcoma of Face	1 year
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
	Neurosarcoma of Face	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 1/24 *19*49 *to* 2/24 *19*49, *that I last saw the deceased alive on* 2/24 *19*49 *and that death occurred at* 9 37 *A.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C DATE SIGNED
Jack Dennett M. D.	SBGH	2/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/28/49	Mount Lawn Park	Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Timothy for Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 150

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G71885 126109 X ✓ G71885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anthony Leskoski

2. DATE OF DEATH: Feb. 21-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): Box 307 RT. 13.-21 Holleyneck Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W			70 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: B.C.H. Records 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Right Upper Lobe of lung.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-16-49, 19__, *to* 2-21-, 1949, *that I last saw the deceased alive on* 2-21, 19 49 *and that death occurred at* 4.30 *m. from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 2-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): [illegible]
24B. DATE: 2/25/49
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cem
24D. LOCATION (City, town, or county) (State): German Hill Road

DATE RECEIVED BY LOCAL REGISTRAR: FEB 2
REGISTRAR'S SIGNATURE: Turlington for Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: John J. Fahey & Sons - 195 Light St.

VS 150

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G71886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G71886

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HAMELIA JORDAN

2. DATE OF DEATH: 2/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md. General Hospital
c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1814 Madison Ave. 14-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	Married	1/31/98	51 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Interior Decorator		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Jordon	Catherine Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
Yes	7/15/18-3/17/19	218-40-0007	Wife.	1814 Madison Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cancerous of Bladder	
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil L. Rogers			2/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/26/49	Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Eugene H. Mayo.	825 52B Harlem ave

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71887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20 8

G71887

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): MARY ELINORE THOMPSON

2. DATE OF DEATH: Feb. 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3707 Greenmount Avenue

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3707 Greenmount Avenue 9-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	July 15, 1859	89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk - retired	O'Neills	Baltimore, Md.	USA

13. FATHER'S NAME: Capt. John A. Thompson

14. MOTHER'S MAIDEN NAME: Martha Jane Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
no	none	4003 Ridgewood Avenue Miss Mary V. Randall-

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 Weeks

DUE TO

(B) Arteriosclerosis (Generalized) — 10 Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: None

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/14, 1949, *to* 2/24, 1949, *that I last saw the deceased alive on* 2/20, 1949, *and that death occurred at* 11 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Grafton Hersperger M. D.	214 Medical Art Bldg	2/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/28/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 25 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC.

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BALTIMORE - 18, MARYLAND

9-D

G71888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

BIRTH NO. G71888 Registered No.

1. NAME OF DECEASED (Type or Print): Mary M. Moore.

2. DATE OF DEATH: Feb. 23 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 622 N. Bruce St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 622 N. Bruce St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	C	married	Aug. 22, 1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Middlesex Co. Va.	U.S.A.

13. FATHER'S NAME: John Brafton.

14. MOTHER'S MAIDEN NAME: Alice Robinson.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Joseph Moore ADDRESS: 622 N. Bruce St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage - left side — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Malignant Hypertension — ? ?

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 18 *19*49 *to* Feb. 23 *19*49 *that I last saw the deceased alive on* Feb. 23, 19 49, *and that death occurred at* 2 30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 1 E. Lexington St.

23C. DATE SIGNED: 2-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Feb 25, 1949	National Cemetery	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Mrs Katie R Williams	3221 W

VS 150

839

71889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No. 71889

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bessie Stulman

2. DATE OF DEATH: 2-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. 15 04
D. STREET ADDRESS (If rural, give location): 3927 Norfolk Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	W	(Widowed)	Feb 1879	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HW		Russia	

13. FATHER'S NAME: Shika ?

14. MOTHER'S MAIDEN NAME: Mollie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs David Gottlieb ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Hypertensive CV Disease — INTERVAL BETWEEN ONSET AND DEATH: 5

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO:

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Diabetes Mellitus — ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-10, 1949, *to* 2-24, 1949 *that I last saw the deceased alive on* 2-24, 1949, *and that death occurred at* 11 20 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. J. Laham, M. D.	Franklin Sq Hosp.	2-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-25-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

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G71890

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 443

Registered No. G71890

1. NAME OF DECEASED (Type or Print): Lilian Dowell

2. DATE OF DEATH: 2-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt
D. STREET ADDRESS (If rural, give location): 3024 Keswick Rd. 1 2 CS

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 4/17/1884
9. AGE (In years last birthday): 64 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HW
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Texas Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Husband
ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral - hemorrhage
DUE TO
(B) Hypertensive CV Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 da

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-14, 1949, *to* 2-23, 1949, *that I last saw the deceased alive on* 2-23, 1949, *and that death occurred at* 4:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. J. Laham M. D.
23B. ADDRESS: Franklin Sq Hosp.
23C. DATE SIGNED: 2-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 26-49
24C. NAME OF CEMETERY OR CREMATORY: Woodland Mem Pk
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, Jr.
25. FUNERAL DIRECTOR: Frank H Seitz
ADDRESS:

VS 150

937

G71891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

Registered No. G71891

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Luba Sagal

2. DATE OF DEATH Feb 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 4007 Springdale Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 45 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4007 Springdale Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widower	1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
house wife		Russia	

13. FATHER'S NAME: Zolman Kazamnovsky

14. MOTHER'S MAIDEN NAME: Leah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Estelle Glickman	4007 Springdale Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral hemorrhage	8 weeks
DUE TO (B)	Hypertension	10-15 yrs
DUE TO (C)	Arterio-sclerosis	" "
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Mitral-stenosis	Since infancy

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan-1-1949 *to* Feb-24-1949 *that I last saw the deceased alive on* Feb-24-1949 *and that death occurred at* 3.25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herman Seidel M. D.	2404 Eutaw Pl	2/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 25, 1949	Hebrew Rosedale Cem	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Levinson & Bros	1126 W North Ave

VS 150

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71892 BALTIMORE CITY HEALTH DEPARTMENT 71892

CERTIFICATE OF DEATH 420

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) FRANK J. PRICE

2. DATE OF DEATH February 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2624 Hudson Street
c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 2624 Hudson St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	July 28 1905	43 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER	AMERICAN CAN		

13. FATHER'S NAME JOHN PRICE
14. MOTHER'S MAIDEN NAME CATHERINE SMIELKAL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no			STELLA PRICE	2624 Hudson st.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE George G. Merrill M.D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 2-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/28/49	St. STANISLAUS CEM	Dundalk AVE

DATE RECEIVED BY LOCAL REGISTRAR FEB 25 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR STEPHEN J. FALKOWSKI INC ADDRESS 1000 SHENWOOD Ave

VS 151

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G71893

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71893

BIRTH NO. 1 5 Registered No.

1. NAME OF DECEASED (Type or Print): JOHN A. BANASZEWSKI

2. DATE OF DEATH: FEB. 23 / 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3001 Elliott St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 1-O
D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore: 40 yrs (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
MALE	WHITE	MARRIED	MAR-21 1876	72 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PENSION-	CON. CAN. CO.	POLAND	

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cancer (in the abdominal cavity)	6 months
DUE TO (B)	Unknown	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	none	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	none	none

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	none WHILE AT WORK ☐ NOT WHILE AT WORK ☐	none

22. *I hereby certify that I attended the deceased from* Septemb., 1948, to Feb. 23, 1948, *that I last saw the deceased alive on* Feb. 22, 1949, *and that death occurred at* 3 4 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. A. Rosenblatt M. D.	3018 O'Donnell St.	2-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/26/49	St. Stanislaus Cem.	Dundalk Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Stephen J. Trakowski & Sons	5 E

VS 150

G71894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71894

BIRTH NO.

1. NAME OF DECEASED (Type or Print): VERNON HENRY WEAVER

2. DATE OF DEATH: Feb. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Marine Hospital, Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: Yrs. 100 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 114 Linden Terrace

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Single	10/14/10	37	4	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chief Mate	Seafarer	Md.	USA

13. FATHER'S NAME: Henry Weaver

14. MOTHER'S MAIDEN NAME: Eleanore Book

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	082-16-5144	Records- US Marine Hospital	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hodgkin's disease	Unknown
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	Due to Contributing causes: (B) (a) meningitis (b) pleurisy) purulent (c) pericarditis (d) peritonitis)	Unknown
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Nov. 16, 1948 *to* Feb. 24, 1949, *that I last saw the deceased alive on* Feb. 24 1949 *and that death occurred at* 3 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	US Marine Hospital, Balto. Md.	2/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 26, 1949	Parkwood Cemetery	Parkville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	John Burns' Sons, Towson, Maryland	

VS 150

446

671895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E900.0 671895

Registered No. N-602

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. MARY KRAMER

2. DATE OF DEATH: 2-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPH'S HOSPITAL
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 3816 WOODLEA AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEM.	W.	WID.	5-84	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HWFE.	at home	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Stumpf	Margaret Ketzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no.	none	Otilla Robinson	3816 Woodlea Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) INTRA-CEREBRAL Hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Fractured skull — DUE TO

(C) — DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 20 hours

CERTIFICATION APPROVED BY
Earl L Kruger
for: Wm. G. Helfrich M.D.
CHIEF OR ASST MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
ACCIDENT	ABOUT HOME	3816 WOODLEA AVE.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
2-22-49 4:30 P.M.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	FELL OFF STEPS

22. *I hereby certify that I attended the deceased from* 2-22 *, 19*49 *to* 2-23 *, 19*49 *that I last saw the deceased alive on* 2-23 *, 19*49 *and that death occurred at* 12:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Joseph Krejci M.D.	1400 N. Caroline St	2-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/26/49	Oak Lawn	Baltimore Co Extended

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams M.D.	Lilly & Gilmore	402 S. Gay St.

VS 150

186a

G71896

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 59

Registered No. G71896

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Emrick

2. DATE OF DEATH: 2/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 116 S. Curley St.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 116 S. Curleyn St. 1-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Nov. 15, 1863	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Schmidt	Elizabeth Seibel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Catherine Louden	116 S. Curley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO Myocardial Insufficiency

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chr Interstitial Nephritis
DUE TO

(C) Acute Cystitis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1938 *to* Feb. 21, 1949, *that I last saw the deceased alive on* Feb. 21, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. G. Geyer Md M. D.	156 N. Mechanic	2/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/25/49	Baltimore Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Lily & Zeiler, Inc.	Baltimore, Md.

VS 150

131a

G71897

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 193

BIRTH NO. | Registered No. G71897

1. NAME OF DECEASED (Type or Print): GEORGE JACKSON
2. DATE OF DEATH: Feb. 22, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balt. Gen. Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 910 Bridgely St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	Single	Jan 5	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Joe Jackson
14. MOTHER'S MAIDEN NAME: Lottie Brune
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fibrosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 15 Mos
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 6, 1949, *to* Feb 22, 1949 *that I last saw the deceased alive on* Feb 22, 1949, *and that death occurred at* 11⁰⁵ P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John M. Boylan Jr M.D.
23B. ADDRESS: South Balt Gen Hosp
23C. DATE SIGNED: Feb 23 '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/25/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn Ct
24D. LOCATION (City, town, or county) (State): Balto City

DATE RECEIVED BY LOCAL REGISTRAR: FEB 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: ADDRESS: L. L. Brown & Son 1042 W Mont

VS 150

55E

G71898

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

490 Registered No.

G71898

1. NAME OF DECEASED (Type or Print): Charlie Easter

2. DATE OF DEATH: 2/23/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 622 S Eutaw Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY: Baltimore 30, Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location): 622 S. Eutaw Street

c. Length of stay in Baltimore: 2 Yrs. 0 Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Colored	Single	3/15/1889	60	11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alfred Easter

14. MOTHER'S MAIDEN NAME: Otha Merithred

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Lucy Owens ADDRESS: 622 S. Euraw Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: acute Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO:

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/14 *1949 to* 2/23 *1949, that I last saw the deceased alive on* 2/22 *1949, and that death occurred at* 12 40 a *m., from the causes and on the date stated above.*

23A. SIGNATURE: David Swanstein M. D.

23B. ADDRESS: 1112 W Lee St

23C. DATE SIGNED: 2/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/26/49	Mount Auburn Ct	Baltimore, City.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams M. D.

25. FUNERAL DIRECTOR: J. L. Brown & Son ADDRESS: 108 W Monument St

VS 150

108

71899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71899 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DAIZIE SEWALL

2. DATE OF DEATH February 21, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 531 Oxford Street 17-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
female	colored	Divorced		57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		?	

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Daizie Sewall 531

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L. Koons M.D.		Feb. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Feb. 25	Mt Auburn	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	A Halter	931 Druid Hill Ave

VS 151

G71900

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No. G71900

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD HOLLAND

2. DATE OF DEATH 2-20-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto
D. STREET ADDRESS (If rural, give location) 614 W Biddle

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	Col	?	2-1-74	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Md.	

13. FATHER'S NAME Edward Holland

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Self	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

(B) Hypertensive Cardio Vascular disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-10-, 1949 *to* 2-20-, 1949, *that I last saw the deceased alive on* 2-20-, 1949, *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ellyn R. Judd M. D.	Mercy Hospital	2-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	2-23-1949	Mt Calvary	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	A Halstead & Son	931 Hull

VS 150

71901

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 71901

1. NAME OF DECEASED (Type or Print): CHARLES A. RUBENSTEIN.

2. DATE OF DEATH: 2/25/1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland Sheffield Apts

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: ? Yrs. —Mos. —Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Sheffield Apts. (Lake Drive) 13-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	4/13/1870.	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Rabbi	Russia.	U.S.A.

13. FATHER'S NAME: ? Rubenstein

14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
?		Mrs. C. A. Rubenstein, Sheffield Apts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Myocardial insufficiency	9 months
DUE TO (B)	myocardial infarction	1 yr.
DUE TO (C)	Coronary arteriosclerosis	?
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 28, 1948. *to* Feb. 25, 1949. *that I last saw the deceased alive on* Feb. 24, 1949. *and that death occurred at* 1:50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert M. Gundersheimer, M.D.	Riviera Apts.	2/25/1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	2/28/1949.	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 25 1949	Huntington Williams, Jr.	Harry Sonneborn & Son 1902 Eutaw Place.

VS 150

940a

G71902 KLEHN ✓385 G71902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 444

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Louisa K. LEHM

2. DATE OF DEATH: 24 FEB 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore Eye & Ear Hospital - 124 Gates Lane

C. Length of stay in Baltimore: 87 yrs - 10 mos 17 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto — B. COUNTY: Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3515 E. Fayette Street (24) 6 02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	13 May 1862	86 87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	None	Baltimore - Md	U.S.

13. FATHER'S NAME: John Leffler

14. MOTHER'S MAIDEN NAME: Barbara Z Inheel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Daughter — Mrs. L. M. Reed — ADDRESS: 3515 E. Fayette St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
I (A)	Hypertension.	—
DUE TO (B)	Cataract Operation 18 Feb 49	6 Days
DUE TO (C)	Heart Failure	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
18 Feb 1949	Mature Cataract right Eye	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None	None

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	None

22. *I hereby certify that I attended the deceased from* 12 Feb, 1949, *to* 24 Feb, 1949 *that I last saw the deceased alive on* 12:55 am, 24 Feb 49 *that death occurred at* 11:55 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph E. Brumbeck Jr. M. D.	Balto. Eye & Ear Hospital	24 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/28/49	London Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Ulrich Funeral Home	2500 Eastern Ave

VS 150

102

71903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 420

G71903

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): ROSA LEE BURNHAM

2. DATE OF DEATH: Feb. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3226 Ellerslie Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 3226 Ellerslie Ave.

5. SEX	6 COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
female	white	widow	Jan. 17, 1865	84 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
housewife		Maryland	

13. FATHER'S NAME: Daniel C. Gray

14 MOTHER'S MAIDEN NAME: Annie Shepard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
no		XX	Mrs. Clara E. Tenz	3226 Ellerslie Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 14 mo.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/10 1941, *to* 2/23, 1949 *that I last saw the deceased alive on* 2/23, 1949, *and that death occurred at* 10 50 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Robert A. Reate, M. D.	3408 Wendover Ave	2/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial--	2/28/49	Stone Chapel	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Wm. J. Fichter & Sons	Balto., Md.

VS 150

93D

G71904

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-34.1 G71904

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Mary Jefferson Brooks

2. DATE OF DEATH: 2/22/49

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

b. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 409 E. 21½ St. 12-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	married	March 21 1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	H	Balto Md	

13. FATHER'S NAME: Thos Swann

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Abraham Brooks	409 E 21½ St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Heart Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L Pope M.D

23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR

23C. DATE SIGNED: 2/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 26/49	Mt Calvary Cem	A A County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Mrs Robt A Elliott & Daughter	93E 1129 N. Carlton St

VS 151

✓ 260

G71905 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71905 — Registered No.

1. NAME OF DECEASED (Type or Print): Ella Kampe

2. DATE OF DEATH: Feb. 23. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: BALTIMORE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2823 Kirk Ave
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2823 Kirk Ave 9-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	White	Widowed	1865	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MARYLAND	

13. FATHER'S NAME: ? Mitchell

14. MOTHER'S MAIDEN NAME: ? LaRoe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT, ADDRESS
		Mr. Killian Kampe 2822 Kirk Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs
DUE TO
(B) Coma — 3 Days
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* [illegible], 19[illegible] to Feb 23, 19[illegible], *that I last saw the deceased alive on* [illegible], 19[illegible], *and that death occurred at* ____ m., *from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. N. O'Donovan M. D.	3176 Hartford Rd	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 26, 1949	Parkwood	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	John O. Moran	3000 Boston St.

VS 150

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G71906

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

196 Registered No. G71906

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Mendelus

2. DATE OF DEATH Feb. 24/49

3. PLACE OF DEATH
A. Baltimore City, Maryland 309 S. Duncan St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE
B COUNTY 309 S Duncan St
C CITY OR TOWN (If outside corporate limits, write RD, RFD, and give township) Baltimore
D STREET ADDRESS (If rural, give location) 309 S. Duncan St

c. Length of stay in Baltimore Yrs. 1 Mos. 0 Days 5

5 SEX	6 COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Married	See 26-1883	66 65		

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Home Wife	at Home	Poland	

13. FATHER'S NAME Martin Wojtczak

14. MOTHER'S MAIDEN NAME Kuzara

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT	ADDRESS
—	no	none	John Mendelus	309 S. Duncan St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
A. Cancer of the left superior maxilla & left malar bone
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
B.
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 5 mo.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT SUICIDE HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-6-, 1948 *to* 2-24-, 1949 *that I last saw the deceased alive on* 2-23-, 1949, *and that death occurred at* 3A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. J Davidow M.D.	3218 Eastern ave	2-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24A. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, County, State)
Burial	Feb. 28/49	St Stanislaus Cem	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Fred W. Ozazewski	1980 Eastern Ave

VS 150

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BIRTH NO. 571907

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 581.8

Registered No. 671907

1. NAME OF DECEASED (Type or Print): Henry WEBER

2. DATE OF DEATH: 24 Feb 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 4925 Belair Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
Male	White		17 Jul 01	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tavern Proprietor		GERMANY	U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs. Henry Weber	4925 Belair Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	RUPTURED ESOPHAGEAL VARICES	One Hour
DUE TO (B)	CIRRHOSIS of LIVER	2 Years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
N/K M.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 24 Feb, 1949 *to* 24 Feb, 1949 *that I last saw the deceased alive on* 24 Feb, 1949, *and that death occurred at* 7 1/2 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Roman V. Ulan M. D.	Franklin Square Hosp.	24 Feb 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	2/27/49	St. Michaels	Perry Hall, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Lassahn Funeral Home	7101 Belair Rd.

VS 150

124 B

G71908

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

Registered No.

G71908

1. NAME OF DECEASED (Type or Print): Mary A. Handy

2. DATE OF DEATH: Feb 24th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 172 N. Ellington Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 172 N. Ellington Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
Female	White	Widowed	5/17/1874	74	9 9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Dundalk, Ireland	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs. Ruby Tuohy	172 N. Ellington Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemmorhage — (INTERVAL BETWEEN ONSET AND DEATH) 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis, Hypertension

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/15/ 1949 *to* 2/23/ 1949 *that I last saw the deceased alive on* 2/23/ 1949, *and that death occurred at* 1:20 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
A. Weiss M. D.	1927 E. North Ave.	2/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	2/26/49	Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

83a

671909 671909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Walter Tarrell

2. DATE OF DEATH: 2/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1336 Aisquith St
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1336 Aisquith St. 9 09

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	2/31/1890	58	1 23	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor	Reid-Murry Co	Raleigh Co. W. Va.	

13. FATHER'S NAME: William Tarrell

14. MOTHER'S MAIDEN NAME: Ella Tarrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Ethel C. Tarrell	1336 Aisquith St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Coronary Occlusion	10 hrs
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)		
	DUE TO (C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 24, 1948 *to* Feb 24, 1949 *that I last saw the deceased alive on* Feb 24, 1949, *and that death occurred at* 3 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph Friedman M. D.	404 E. North Ave	Feb 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	2/25/49	Oak Hill	W. Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 26 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

94a

G71910

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 4772 G71910

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Percy B. BELL

2. DATE OF DEATH: Feb 23 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1550 W. Lombard St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1550 W. Lombard St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Married	March 31-1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore Md	

13. FATHER'S NAME: William Bell

14. MOTHER'S MAIDEN NAME: Hester Bromwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No

16. SOCIAL SECURITY NO. (If yes, give war or dates of service): 218-05-4789

17. INFORMANT: Theresa Bell ADDRESS: 1550 W Lombard St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 18, 1949, *to* Feb 23, 1949, *that I last saw the deceased alive on* Feb 23, 1949, *and that death occurred at* 12 05 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert Seagrotti M. D.	1729 W Lombard St	2/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 26, 1949	Meadowridge	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	R. C. & B. M. Walters	Pratt & Strieker

VS 150

93D

G71911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443

Registered No. G71911

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna M. Maloney

2. DATE OF DEATH: 2/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jenkin's Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dayton
D. STREET ADDRESS (If rural, give location): Dayton, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	W	W	10/18/79 ?	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Clarksville, Md.	USA

13. FATHER'S NAME: Thomas O'Neil

14. MOTHER'S MAIDEN NAME: Anna Cooney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	NONE	Family	Dayton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Hypertensive Arteriosclerotic C-V Dis — —

DUE TO a Relative Mitral Insuff.

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Advanced Rheumatoid Arthritis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from June '5 1948 to 2/24 1949, that I last saw the deceased alive on 2/23 1949 and that death occurred at 3:15 A.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thos. E. Carr Jr. M. D.	St. Agnes Hosp.	2/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-26-49	St Stanislaus	Clarksville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.	J. C. Heginbotham Jr	

VS 150

920

G71912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71912

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Larash, Henrietta R.

2. DATE OF DEATH: Feb 24 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for the Women of Maryland

c. Length of stay in Baltimore: 3 Yrs. 4 Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4208 Ridgewood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	Mar. 6, 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Pennsylvania (Philadelphia)

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Reading, Charles

14. MOTHER'S MAIDEN NAME: Lewis, Sarah F

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No — —

16. SOCIAL SECURITY NO: 213-26-0060

17. INFORMANT: herself ADDRESS: —

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I (A) Carcinoma bladder — INTERVAL BETWEEN ONSET AND DEATH: 14 mos.

DUE TO (B) —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C) —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: Jan.-Mar. 1948

19B. MAJOR FINDINGS OF OPERATION: Radium application

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): None

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Feb 10, 1949, *to* Feb 24, 1949 *that I last saw the deceased alive on* Feb 24, 1949, *and that death occurred at* 2:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ebert T. Bennett M. D.

23B. ADDRESS: Hosp. for Women of Md.

23C. DATE SIGNED: Feb 24 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 2/26/49

24C. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery

24D. LOCATION (City, town, or county) (State): Drexel Hill, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 25 1949

REGISTRAR'S SIGNATURE: (Remington Williams, M.D.)

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

52B

G71913

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

Registered No. G71913

1. NAME OF DECEASED (Type or Print): JOHN RASCH

2. DATE OF DEATH: 2/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 704 Bartlett Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
704 Bartlett Ave, Baltimore, Md.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore, Md.
D. STREET ADDRESS (If rural, give location)
704 Bartlett Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 1 day: Hours, Min.
Male	White	Divorced	1874	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Rasch

14. MOTHER'S MAIDEN NAME: Dorothea Litchke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO: -

17. INFORMANT: Mr. Adam Uhl — ADDRESS: 704 Bartlett Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	6 mos
DUE TO (B)	Arteriosclerosis (General)	8 yrs
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1949 *to* Feb. 24, 1949, *that I last saw the deceased alive on* Feb 24, 1949, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas J. White M. D.

23B. ADDRESS: 3909 Greenmount Ave

23C. DATE SIGNED: 2/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/26/49	Mt. Carmel Cem.	City

DATE RECEIVED BY LOCAL REGISTRAR: FEB 25 1949

REGISTRAR'S SIGNATURE: Emily for Williams, M.D.

25. FUNERAL DIRECTOR: WIEDEFELD & SON — ADDRESS: GREENMOUNT AVE & 22ND

VS 150

83a

Birth Cert # 49-02497

71914

CERTIFICATE CORRECTED 3-14-49 ✓

G71914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 751

BIRTH NO. B.C. 49-02497 Registered No.

1. NAME OF DECEASED (Type or Print) (Christian) (Middle) Milburn (Last)

2. DATE OF DEATH 2/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - Md.
D. STREET ADDRESS (If rural, give location) 2717 Spellman Rd. 32

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sydenham Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year Months	If Under 24 Hours Hours	Min.
Female	Colored	Single	Feb. 1 - 1949				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child		Baltimore - Md.	U.S.

13. FATHER'S NAME Wilbert Johnson

14. MOTHER'S MAIDEN NAME Mrs Evelyn Milburn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Mother.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Meningitis	2 days
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Hydrocephalus	10 days
DUE TO		
(C)	Meningo myelocele	23 days
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Rectovesical Fistula.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/21, 1949 *to* 2/24, 1949 *that I last saw the deceased alive on* 2/24, 1949, *and that death occurred at* 7:10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jon Cohen M. D	Sydenham Hosp-tal	2/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremated	2/25	John Hopkins Hosp.	Balt. more - Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 25 1949	Huntington Williams, M.D.		

VS 150

157a

G71915

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71915

Registered No.

1. NAME OF DECEASED (Type or Print): Luther Milton Parsons

2. DATE OF DEATH: Feb 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 225 Hawthorn Rd

C. Length of stay in Baltimore: 64 Yrs. 5 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 225 Hawthorn Rd Roland Park

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M.	W	Married	Mar 21 1873	75	11	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dentist		Sparks Balto Co Md	—

13. FATHER'S NAME: Elisha Lee Parsons

14. MOTHER'S MAIDEN NAME: Susann Warner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	Paul S Parsons	5203 Burlington Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Leukemia, Monocytic, Sub acute — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
(B) unknown
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Arteriosclerosis, generalized, Arteriosclerotic Heart Disease; Diabetes mellitus mild

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 1944 *to* Feb 23 1949 *that I last saw the deceased alive on* Feb 22 1949, *and that death occurred at* 805 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Morton L Sugarman M. D.	1109 St Paul St	2/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 26/49	Druid Ridge	Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 26 1949	Huntington Williams, M.D.	Henry N Jenkins Sons	4905 York Rd

VS 150

74a

G71916 — BALTIMORE CITY HEALTH DEPARTMENT — G71916

CERTIFICATE OF DEATH

4 no. 1

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Joseph M. Dower

2. DATE OF DEATH: 2/24/49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

c. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 636 Rappola St. 26-05

5. SEX: Male
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: 8/14/1896
9. AGE (In years last birthday): 52 — If under 1 year: Months 6, Days 10; If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel Co Key Highway
11. BIRTHPLACE (State or foreign country): Westerly R.I.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nicholas Dower
14. MOTHER'S MAIDEN NAME: Annie Pierce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: 4 Gavitt Place Mrs. Joseph Dower Westerly R.I.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* ~~Inspection~~ Autopsy, Inspection or Inquiry & In... *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Paul L Boyer M.D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 2/25/49

24A. ~~BURIAL, CREMATION~~ REMOVAL (Specify): Removal
24B. DATE: 2/26/49
24C. NAME OF CEMETERY OR CREMATORY: Westerly
24D. LOCATION (City, town, or county) (State): Westerly R.I.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 26 1949
REGISTRAR'S SIGNATURE: Investigator Williams
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 151

94a

G71917

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71917

Registered No.

1. NAME OF DECEASED (Type or Print): NANCY E. BOYD

2. DATE OF DEATH: Feb. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1931 Deering Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1931 Deering Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Widow	Jan. 26, 1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Newburyport, Mass	

13. FATHER'S NAME: Owen P. Sargeant

14. MOTHER'S MAIDEN NAME: Sally A. Eaton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mrs. Harry Sturgis, 1931 Deering Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 23, 1949 *to* Feb 25, 1949, *that I last saw the deceased alive on* Feb 23, 1949, *and that death occurred at* 12 M *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Arthur Rawlings M.D. M. D.	27 W. Mad. St. Balt 30	2-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	2/26/49	Long Hill	Salisbury, Mass.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 26 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

94a

71918

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71918

Registered No.

1. NAME OF DECEASED (Type or Print): Charles Schreiber

2. DATE OF DEATH: Feb. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1913 Eutaw Place

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twilight Nursing Home

c. Length of stay in Baltimore: Yrs. Lifetime. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2724 Beryl Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	Jan. 29, 1863	86	0	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Huckster		Baltimore, Md.	U.S.

13. FATHER'S NAME: Charles Schreiber

14. MOTHER'S MAIDEN NAME: Henrietta Smhmidt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No.			Henry Schreiber	4511 Mainfield Ave.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic myocarditis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 23, 1949, *to* Feb 24, 1949, *that I last saw the deceased alive on* Feb 23, 1949, *and that death occurred at* 5 4- p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M H Patterson M.D.	2324 Reisterstown Rd	2/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb. 26, 1949	Western	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 26 1949	Huntington Indiana	Ullrich Funeral Home,	2008 Orleans St.,

FEB 26 1949

VS 150

939

G71919

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71919

BIRTH NO. 17.0 Registered No.

1. NAME OF DECEASED (Type or Print): Charles Edward McCall — N803.2

2. DATE OF DEATH: 2/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: B. A.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5807 Belgrove Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	C	Child	April 7, 1943	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James McCall.
14. MOTHER'S MAIDEN NAME: Emma Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: James McCall. ADDRESS: 5807 Belgrove Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of Skull
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street.
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Belgrove Rd. near Pumphrey's Station
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 2-23-49 7 P m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Pedestrian hit by truck

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 2/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-27-49
24C. NAME OF CEMETERY OR CREMATORY: Windsor Cem.
24D. LOCATION (City, town, or county) (State): Windsor N. C.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 26 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Mrs Katie R. Williams
ADDRESS: 322 N. Schroeder St

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G71920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443

Registered No. G71920

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Howard Howell

2. DATE OF DEATH: 2-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 748 Saratoga St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	Col.	Widow	Sept. 24 1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		South Mill N.C.	U.S.A.

13. FATHER'S NAME: Benjamin Howell

14. MOTHER'S MAIDEN NAME: Eliza Hunt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Wilmer Johnson	748 Saratoga St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 60 hr.

DUE TO

(B) Hypertensive Cardio-Vascular Renal

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-22- 1949 *to* 2-22- 1949 *that I last saw the deceased alive on* 2-22 1949 *and that death occurred at* 11 30 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. C. Brady, Jr. M. D.	Provident Hospital	2-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-26-49	Mt. Calvary cem.	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 26 1949	[illegible]	Mrs Katie R. Williams	322 [illegible] St

VS 150

93D

G71921

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 401 · 3

Registered No. G71921

1. NAME OF DECEASED (Type or Print): Catherine M. Reinhardt

2. DATE OF DEATH: Feby 26.1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 4512 Harford Road

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): --------

c. Length of stay in Baltimore: Yrs. five weekd Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 4512 Harford Road
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 4512 Harford Road 27-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	Oct 19.1922	26	4 / 4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Home duties	Lynchburg Va.	U.S.

13. FATHER'S NAME: Frank E. Foster

14. MOTHER'S MAIDEN NAME: Amie M. KKanode

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Frank E. Foster ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho Pneumania

DUE TO

(B) Rheumatic Carditis

DUE TO

(C) Rheumatic Fever

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 1 day

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-25, 1949 *to* 2-26-, 1949 *that I last saw the deceased alive on* 2-26-, 1949 *and that death occurred at* 7:25 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. W. Peake M. D.

23B. ADDRESS: 4508 Harford Road

23C. DATE SIGNED: 2-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: Mch. 1.1949

24C. NAME OF CEMETERY OR CREMATORY: Lynchburg Cem.

24D. LOCATION (City, town, or county) (State): Lynchburg Va.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 26 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: John O. Mitchell & Sons

ADDRESS: 1900 Eutaw Place

John O. Mitchell

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BIRTH NO. 671922

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 671922

1. NAME OF DECEASED (Type or Print): MARGARET E. FALK
2. DATE OF DEATH: 2/23/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1125 WICOMICO ST.
c. Length of stay in Baltimore: LIFE. (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D STREET ADDRESS (If rural, give location): 1125 WICOMICO ST. 2-07

5. SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
FEMALE	WHITE	WIDOWED	MAR. 11, 1888	60	11 12	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	OWN HOME	BALTO. MD.	

13. FATHER'S NAME: CHARLES E. SHEPARD
14 MOTHER'S MAIDEN NAME: SARAH UNKNOWN

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
NO	NO	CHARLES FALK	1125 WICOMICO ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		
	a) CORONARY OCCLUSION	1 DAY
	DUE TO CORONARY ARTERIOSCLEROSIS	
ANTECEDENT CAUSES	b DIABETES MELLITUS	17 MONTHS
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO ARTERIOSCLEROSIS	
	c ARTERIOSCLEROTIC CARDIOVASCULAR RENAL DISEASE	2½ YRS
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒
NONE	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D TIME OF INJURY (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from 18 OCT 48 to 23 FEB 49, that I last saw the deceased alive on 23 FEB 19 49, and that death occurred at 4:00 P m., from the causes and on the date stated above.

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Edward F. Miller M. D.	682 WASHINGTON BLVD	25 FEB 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
BURIAL	2/26/49	Western Cem	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 26 1949	Certified for Milliken, MD	J. J. Ambrose	1328 Sulphur Spring Rd

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G71923 ✓ G71923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 43 Registered No.

1. NAME OF DECEASED (Type or Print): Reuben Augustus Payne

2. DATE OF DEATH: Feb. 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1104 Myrtle Ave.

c. Length of stay in Baltimore: 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1104 Myrtle Ave. 17-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Jan. 1 1892	57	1 23	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur	Private family	Frederick Co. Md.	U.S.A.

13. FATHER'S NAME: Phillip Payne

14. MOTHER'S MAIDEN NAME: Elizabeth Posey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Mrs. Ella Payne	1104 Myrtle Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Arteriosclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1-16, 1949 *to* Feb 24, 1949 *that I last saw the deceased alive on* Feb 24, 1949, *and that death occurred at* 4.55 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mark F. Wadell M. D.	22 E Hoffman St	2-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/28/1949	Chestnut Hill Mem. Park.	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 26 1949	Huntington Williams, M.D.	Wm. George H. Holland	1631 Ave.

VS 150

937

671924

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 671924

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charlotte Meade

2. DATE OF DEATH Feb. 23, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 924 Harlem Ave.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 924 Harlem Ave. 16-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Divorced	Oct. 10, 1888	60	2	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Henry Jones
14. MOTHER'S MAIDEN NAME Ella Goldsborough

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never ashamed) No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Gordon Jones ADDRESS 3449 Woodbourne Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — Interval between onset and death: 3 days
DUE TO
(B) Chronic Valvular Heart Disease ?
DUE TO
(C) Obesity

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 2-8, 1948 to 2-25, 1949 that I last saw the deceased alive on 2-26 1949 and that death occurred at 10 A.M., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles Woodland, M.D.	91 Harlem Ave	2-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/26/1949	Arbutus Mem. Park.	Balto. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 26 1949	Penning for Williams, M.D.	Wm. George H. Holland	1601 Hairhill Ave.

VS 150

92D

G71925

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71925 Registered No. 150

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bella Sherman

2. DATE OF DEATH: 2-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hebrew Aged Home, Levindale

C. Length of stay in Baltimore: 50 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 111 N. Ann Street 6 64

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow W
8. DATE OF BIRTH: 1872
9. AGE (In years last birthday): 76 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Bernard Katz
14. MOTHER'S MAIDEN NAME: Freda Friedlander

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Maurice Sherman ADDRESS: 3225 Spalding Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia
DUE TO
(B) Carcinoma of esophagus
DUE TO
(C) Diabetes mellitus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-11- , 1948 *to* 2-25 , 1949, *that I last saw the deceased alive on* 2-25 , 1949, *and that death occurred at* 2.40 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Jerome J. Blumberg M. D.
23B. ADDRESS: Levindale Home
23C. DATE SIGNED: 2-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-27-49
24C. NAME OF CEMETERY OR CREMATORY: Mickro- Kodesh Cong
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 26 1949
REGISTRAR'S SIGNATURE: Flemington Williams
25. FUNERAL DIRECTOR: S. Levinson & Bros. ADDRESS: 1126 N North Ave

VS 150

46a

71926

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-0 1 G71926-

Registered No.

1. NAME OF DECEASED (Type or Print): Lily Cohen

2. DATE OF DEATH: Feb 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2416 Reisterstown Road

c. Length of stay in Baltimore: 50 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2416 Reisterstown Roaad

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1887
9. AGE (In years last birthday): 61 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Barr
14. MOTHER'S MAIDEN NAME: Freda ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Louis Cohen ADDRESS: 2416 Reisterstown Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(B) Hypertension — 6 mos

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/20, 19 49, *to* 2/25, 19 49, *that I last saw the deceased alive on* 2/25, 19 49, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph D. Blum M. D.
23B. ADDRESS: 115 N. Calvert St
23C. DATE SIGNED: 2/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 27/49
24C. NAME OF CEMETERY OR CREMATORY: Anshei Emunah Cong Hebrew Washington Rd
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1124 W North Av

VS 150

94a

CARTER ✓

G71927

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 002

G71927

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Lonella Carter

2. DATE OF DEATH February 24 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore 35 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1825 E. Chase St. 7 10 4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widowed	8-20-75	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) N. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Manton Woods.

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-20, 1949 to 2-24, 1949, that I last saw the deceased alive on 2-24, 1949 and that death occurred at 3 30 p.m., from the causes and on the date stated above.

23A. SIGNATURE Richard S. Ross M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 2-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 2-28-49

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary

24D. LOCATION (City, town, or county) (State) A-A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 26 1949

REGISTRAR'S SIGNATURE Permission from Baltimore, Md.

25. FUNERAL DIRECTOR ADDRESS Joyner Sanders 1412 E. Preston St 13B

VS 150

414279

1928

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 0 1 0

G71928

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Susie Lewis

2. DATE OF DEATH: FEB 23 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 4 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1213 N. Durham, St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
female	Colored	married	2-16-97	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Henry Derricett
14. MOTHER'S MAIDEN NAME: Sissy Brooker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous Meningitis — (Interval between onset and death): about 3 wks.

DUE TO

(B) Disseminated tuberculosis — (Interval between onset and death): ?

DUE TO disseminated

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES [Y] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-16- *,* 1949 *to* 2-23 *,* 1949 *that I last saw the deceased alive on* 2-23- *,* 1949 *and that death occurred at* 3 5-5 *A.m., from the causes and on the date stated above.*

23A. SIGNATURE: Bertram E. Sprague M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 2/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/27-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Payne Sindere
ADDRESS: 1412 E Preston St

VS 150

14

G71929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 421.4

G71929

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANK A. HOPWOOD

2. DATE OF DEATH: Feb. 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2022 E. North Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ardleigh Nursing Home 2075 Rockrose Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
male	white	single	Feb. 16, 1875	74 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Harpers Ferry, W. Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles L. Hopwood	Charlotte R. Copeland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Valvular heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 22, 1949, to Feb 25, 1949, *that I last saw the deceased alive on* Feb 22, 1949, *and that death occurred at* 3:24 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. H. Patterman M.D.	2214 Fredericksburg Rd	Feb 25 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/28/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 26 1949		C. J. PICKNER & SONS	Balto., Md.

VS 150

927

671930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

671930

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Fannie C. Gingrich

2. DATE OF DEATH: Feb 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12
D. STREET ADDRESS (If rural, give location): 1129 Overbrook Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	Under 1 Year: Months / Days	Under 24 Hours: Hours / Min.
F	W.	widow	Feb. 10, 1879	70 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Palmyra, Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David Book

14. MOTHER'S MAIDEN NAME: Fannie C. Creller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: no

17. INFORMANT: Mr. R. G. Gehr ADDRESS: 1129 Overbrook Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hours ±

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension — ?

DUE TO

(C) Arteriolarsclerosis — ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9 P.M. 2/25, 1949, *to* 8:30 P.M. 2/25, 1949, *that I last saw the deceased alive on* 8:20 P.M. 2/25/49, *and that death occurred at* 8:20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Betty May Young, M.D.

23B. ADDRESS: Maryland General Hospital

23C. DATE SIGNED: 2/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3/1/49

24C. NAME OF CEMETERY OR CREMATORY: Greenmount

24D. LOCATION (City, town, or county) (State): Annville, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 26 1949

REGISTRAR'S SIGNATURE: Terminal for Middletown, etc

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Dallas, Md.

VS 150

83a

G71931

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

Registered No. G71931

1. NAME OF DECEASED (Type or Print): Annie E. Manger

2. DATE OF DEATH: Feb-23-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4213 Massachusetts Ave

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-04
D. STREET ADDRESS (If rural, give location): 4213 Massachusetts Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	Aug. 15-1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore. Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: George M. Manger
14. MOTHER'S MAIDEN NAME: Elizabeth Beck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Emma Keaus ADDRESS: 4213 Massachusetts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral haemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO
(B) arterio sclerosis and hypertension. — several years
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: arteris sclerotic type heart disease - congestive failure - 1 year.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1948, *to* Feb 23rd, 1949, *that I last saw the deceased alive on* Feb 19, 1949, *and that death occurred at* 9:50 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm Michel, M. D.
23B. ADDRESS: 2901 Edmondson Ave
23C. DATE SIGNED: Feb 25 1949

24A. BURIAL / CREMATION / REMOVAL (Specify): Burial
24B. DATE: 2/26/49
24C. NAME OF CEMETERY OR CREMATORY: Leuden Park Cem.
24D. LOCATION (City, town, or county) (State): Bal to. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 26 1949
REGISTRAR'S SIGNATURE: Thomas J. Williams, M.D.
25. FUNERAL DIRECTOR: F. B. Wippert & Son
ADDRESS: 1300 Eutaw Place

VS 150

937

G71932 ✓ E902.0 N-8032 G71932

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) WILLIAM R. STOWERS

2. DATE OF DEATH February 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital

c. Length of stay in Baltimore 9 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 731 School Street 15-C1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	single	Feb. 22, 1932	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Georgia	

13. FATHER'S NAME: Dozier Stowers

14. MOTHER'S MAIDEN NAME: Dellaree Oliver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Dozier Stowers	731 School Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of Skull
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	731 School Street

21D. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED WHILE AT WORK [ ]	NOT WHILE AT WORK [X]	21F. HOW DID INJURY OCCUR?
2	23	49	7.30 P.M.			Probable fall from third story window

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE Earl L Royster M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED Feb. 26, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-1-49	Royston Ga	Ga

DATE RECEIVED BY LOCAL REGISTRAR: FEB 26 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: George G. Kelson ADDRESS: 1303 Pennsylvania Ave

VS 151

186a

BDR

719.33

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 541.0

✓ X G71933 Registered No.

1. NAME OF DECEASED (Type or Print): Jeff Stevens

2. DATE OF DEATH: February 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md. B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Edgewood
D. STREET ADDRESS (If rural, give location): Box 268

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	2-11-13	36 35		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman		Va.	

13. FATHER'S NAME: Floyd Stevens

14. MOTHER'S MAIDEN NAME: Cynthia Rosmake

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Cardio respiratory failure	3 hrs
DUE TO		
(B)	Shock	4 hrs
DUE TO		
(C)	Operative hemorrhage - portal vein	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2/25/49	Bleeding duodenal ulcer -	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-14, 1949 *to* 2-25, 1949 *that I last saw the deceased alive on* 2-25, 1949 *and that death occurred at* 9 10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Milton Edgerton M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	2/26/49		Honaker, Virginia

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 26 1949	[illegible]	Wm Cook Inc. 1217 E. Fayette St.

VS 150

1172

G71934

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 441

Registered No. G71934

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Janitzky

2. DATE OF DEATH: 2/26/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5310 Barbel Ave #6

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General

c. Length of stay in Baltimore: 28 yrs. (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Married	May 2, 1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HW.			—

13. FATHER'S NAME: Karl Crais

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—	—	Wm Janitzky	3436 Harewood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Failure — DUE TO
(B) Hypertension — DUE TO
(C) —

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes

INTERVAL BETWEEN ONSET AND DEATH: 9 days.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/20 19 49 *to* 2/26 19 49 *that I last saw the deceased alive on* 2/25 19 49 *and that death occurred at* 5:00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edwin J. Black, M.D.	Maryland General	2/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/1/49	St Michaels Luth.	Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 27 1949	Huntington Williams, M.D.	Lanahan Funeral Home	7401 Bene Rd.

VS 150

61

G71935 ✓ 7230 G71935

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Margaret K Peregoy
2. DATE OF DEATH: Feb 25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 26 W 25th St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 26 W. 25th St. 12 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Jan 5 1867	82	11	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Wm B. Peregoy
14. MOTHER'S MAIDEN NAME: Elizabeth C MacFarlane
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs Allan B Stout ADDRESS: 26 W 25th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cardiovascular disease	4 yrs.
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Arteriosclerosis	10 yrs
DUE TO		
(C)	Arthritis deformans.	10 yrs
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1939, 19—, *to* Feb 25, 1949, *that I last saw the deceased alive on* Feb 24, 1949, *and that death occurred at* 6.20 m., *from the causes and on the date stated above.*

23A. SIGNATURE: George H E Cross M. D.
23B. ADDRESS: 28 W 20th St
23C. DATE SIGNED: 2-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/28/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: C. J. Fanning & Son ADDRESS: 1938 E Lafayette Ave

FEB 27 1949

93c

G71936

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

G71936 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma Scott

2. DATE OF DEATH: Feb. 24 49

3. PLACE OF DEATH: A. Baltimore City, Maryland / Balto. Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md
D. STREET ADDRESS (If rural, give location): 655 N. Paca 17 01

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 655 N. Paca

c. Length of stay in Baltimore: 43 7 5 (Yrs. Mos. Days)

5. SEX: Female
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Apr 19 1890
9. AGE (In years last birthday): 58 (If under 1 year: Months 10, Days 5; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): St Mary's Co, Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jas. Gough
14. MOTHER'S MAIDEN NAME: Drucilla Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.*
17. INFORMANT: William H. Scott ADDRESS: 655 N. Paca

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 23 1949 *to* Feb 24 1949 *that I last saw the deceased alive on* 2-24 1949 *and that death occurred at* 6 50P *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. Edward Fisher M. D.
23B. ADDRESS: 1612 E Monument St
23C. DATE SIGNED: 2-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/26/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 27 1949
REGISTRAR'S SIGNATURE: [illegible] for Baltimore, Md.
25. FUNERAL DIRECTOR: Mrs. George H. Holland ADDRESS: 1631 Druid Hill Ave 83a

VS 150

B.L.49-04233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

760.5

G71937 Registered No.

BIRTH NO. G71937

1. NAME OF DECEASED (Type or Print): Baby Boy Kunsky

2. DATE OF DEATH: Feb. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN: (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location): 1104 E. Clinton St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	White	—	2/25/48	30 ?		15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Norman Kunsky	Grace Redemann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Sub-arachnoid hemorrhage	15 hrs.
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C) Prematurity	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Feb. 25, 1949 *to* Feb. 26 1949 *that I last saw the deceased alive on* Feb. 26 1949, *and that death occurred at* 11 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Irene Rhrenthi M. D.	JOHNS HOPKINS HOSPITL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/28/1949	Mossland Park	Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTERED	25. FUNERAL DIRECTOR	ADDRESS
FEB 27 1949		Wm Cook Inc.	127 St. Paul St.

VS 150

160a

G71938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 38

G71938

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JENNIE PITTMAN

2. DATE OF DEATH Feb. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1526 N. Maderia St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 1526 N Maderia St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Widow	April 3, 1853	95		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Lilian, Va.	

13. FATHER'S NAME John Flint

14 MOTHER'S MAIDEN NAME Nancy Morrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No			Mrs Alta Mohlenrich	1706 W. Lombard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Lobar bronchopneumonia	2 days
DUE TO (B)	Cerebral hemorrhage accident thrombosis	1 week
DUE TO (C)	Essential Hypertension	?
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Senility	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1946, *to* Feb 25, 1949, *that I last saw the deceased alive on* Feb 25, 1949, *and that death occurred at* 1.25 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Lenard Brull M. D.	1221 N. Eutaw Ave	2/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Removal	2/28/49	Roseland	Rockville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 27 1949	Huntington Williams, M.D.	Wilson Rose	1214 Park St

VS 150

82a

G71939

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 71939

1. NAME OF DECEASED (Type or Print): HATTIE PACANIA

2. DATE OF DEATH: Feb 23- 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 525 W Franklin

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 14 Yrs 8 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 525 W Franklin St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F.	W.	M.	June 18. 1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Houston Texas	

13. FATHER'S NAME: Neal Davidson

14. MOTHER'S MAIDEN NAME: Hattie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Cardiac Dilitation	3 days
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Hypertensive Cardio Vascular Disease	?
	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 14 46, 19__, *to* Feb 21, 19 49, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Shipsman M. D.	753 W Fayette St	Feb 24 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/28/49	St. Peters	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 27 1949	Huntington Williams, M.D.	Wm Cook. Inc.	1217 St Paul St

VS 150

93D

G71940

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 794

Registered No. ~~4719~~ (1)

1. NAME OF DECEASED (Type or Print): LEA AHRENS.

2. DATE OF DEATH: FEBRUARY 26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2432 REISTERSTOWN RD 17

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2432 REISTERSTOWN RD 17

c. Length of stay in Baltimore: 80 YEARS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE SAME
B. COUNTY 24 8
C. CITY OR TOWN (If outside corporate limits, write RAL and give township) Baltimore 15-04
D. STREET ADDRESS (If rural, give location) 2432 Reisterstown Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
FEMALE	WHITE	WIDOWED	JAN 18-1854	95		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FUNERAL DIRECTOR	FUNERAL DIRECTOR	GERMANY	U-S-A.

13. FATHER'S NAME: FERDINAND KAHN

14. MOTHER'S MAIDEN NAME: HENRIETTA BLUM.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	NO	X	Minna Ahrens	2432 Reisterstown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) senility
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give street location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 15 *, 1944, to* Feb 26 *1949, that I last saw the deceased alive on* Feb 26, 1949, *and that death occurred at* 10:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. H. Patterman M.D.	2324 Reisterstown Rd	2/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town or County) (State)
BURIAL	MARCH 1st-49	OHEB SHALOM CEM	O'DONNELL ST

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 27 1949	Huntington Williams M.D.	J. AHRENS CO	2432 REISTERSTOWN RD

VS 150

1628

WELCER

G719:1

G719p1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Antonia Welcer

2. DATE OF DEATH: Feb. 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sisters of the Poor Home for the Aged Poor

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5546 Horton Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F.	W.	W.	April 6, 1861	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Germany	Yes

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Helen Demaking	1200 Valley St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute Dilatation of Heart	1 day
DUE TO	Chronic Myocarditis	5 yrs
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO	Senile Sclerosis	10 yrs
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 1, 1949, *to* Feb 24, 1949, *that I last saw the deceased alive on* Feb 24, 1949, *and that death occurred at* 5:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E Gill Hall M. D.	1631 E North ave	Feb 25 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Feb 28-1949	Feb 28-1949	Holy Cross Cem	Anne Arundel County

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 27 1949	Huntington Williams, M.D.	Bernard Horle	121 E West St

VS 150

93D

BIRTH NO. G71942

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4/16 Registered No. G71942

1. NAME OF DECEASED (Type or Print): Jacob Hoffman

2. DATE OF DEATH: 2/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai

c. Length of stay in Baltimore: 35 Yrs. ~~Mos. Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1621 Linton Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed		77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Poland	

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-10-8819

17. INFORMANT: Elliott Hoffman ADDRESS: 1621 Linton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure

DUE TO

(B) Rheumatic Ht. Dis

DUE TO

(C) Arteriosclerotic Ht. Dis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/28, 1949 *to* 2/25, 1949 *that I last saw the deceased alive on* 2/25, 1949, *and that death occurred at* 6:50 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marjorie Oxman M. D.

23B. ADDRESS: Sinai Hosp Baltimore

23C. DATE SIGNED: 2/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-27-49

24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 27 1949

REGISTRAR'S SIGNATURE: Lamington Williams, M.D.

25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

93c

G71943

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1949

G71943 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MEYER GOLDSTEIN
2. DATE OF DEATH: 2-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Colonial Home
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1612 No Appleton St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
Male	White	Widowed		82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lith
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Bernard
14. MOTHER'S MAIDEN NAME: Chia
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Carroll Goldstein ADDRESS: 1013 St Paul St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	20 min.
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Arteriosclerosis	?
DUE TO		
(C)	Hypertension	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-26 1949 *to* 2-26 1949 *that I last saw the deceased alive on* 2-26 1949 *and that death occurred at* 6:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE: William L. Feamy M. D.
23B. ADDRESS: 3025 Relair Road
23C. DATE SIGNED: 2-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-27-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: FEB 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Place

94a

G71984 ✓ G71984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CLARA SOLDEN

2. DATE OF DEATH: 2-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2208 Presstman St
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2208 Presstman St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed		63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Russia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Abraham	Jelle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Joseph Golden	2208 Presstman St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

a. Acute Coronary Thrombosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

b. Myocarditis — DUE TO

c. Hypertensive Cv. disease.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 7 1945 *to* Feb. 26 1949, *that I last saw the deceased alive on* Feb 26 1949, *and that death occurred at* 4P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
N E Needle M. D.	9514-20 North Dr	2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	2-27-49	Rosedale	Balto	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 27 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

92D

G71945

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B.C 49-22130 Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS SMITH, JR
2. DATE OF DEATH: Feb 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL
C. Length of stay in Baltimore: 4 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 216 E. Cross St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W	S	[illegible] 1948	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
None	None		

13. FATHER'S NAME: THOMAS SMITH, SR
14. MOTHER'S MAIDEN NAME: Theresa C. Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
NO	—	—	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DIARRHEA with shock dehydration + Toxicity + acidosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

(B) Undetermined Cause

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: none

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
0	0	0

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
0 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	0

22. *I hereby certify that I attended the deceased from* Feb 24, 1949 *to* Feb 25, 1949 *that I last saw the deceased alive on* Feb 25, 1949 *and that death occurred at* 5:25 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allen Y. Wolinska M.D.	Sinai Hospital	2/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR / ADDRESS
Burial	2/28/49	Mt. Holy Cross	Pikesville Md.	Chas. Earle Inc.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 27 1949

VS 150

1190

G71946

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 490

G71946
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Agnes Thaxton
2. DATE OF DEATH: 2-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore - Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2711 Spellman Road, 3A.
C. Length of stay in Baltimore: 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 25
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2711 Spellman Rd. 3A

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro.	Widowed.	8/17/1891	57 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
None		Pearson County, N.C.	U.S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Christine Bumpass.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Charles Neel	2711 Spellman Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia, Lobar — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 15 days.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 11 1949, to Feb 26, 1949, *that I last saw the deceased alive on* Feb. 26th 1949, *and that death occurred at* 9:05 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jerry L. Fruck M.D.	303 Bridgeview Road Balto.	2-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/1/49	Mt Bethel	Roxboro N. Carolina

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 27 1949	Hamilton Williams M.D.	Joseph L. Russ	1200 McCulloh St Balto 17 Md

VS 150

108

MEDICAL EXAMINER'S OFFICE G71947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 581.0

G71947

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Harry Edward Heffner

2. DATE OF DEATH: Feb. 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 14 E. Overlea Avenue

c. Length of stay in Baltimore: 25yr. (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Married	2-5-00	49yr.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Glenn L. Martin	Machinist	Waynesboro, Penna.	U.S.A.

13. FATHER'S NAME: John E. Heffner

14. MOTHER'S MAIDEN NAME: Jennie P. Benhoff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Anna E. Heffner ADDRESS: 14 E. Overlea Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema

DUE TO

(B) Portal Cirhosis.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/23/ , 1949, *to* 2/25/ , 1949, *that I last saw the deceased alive on* 2/25/49 , 19 , *and that death occurred at* 2:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: William A. Rodgers M.D.

23B. ADDRESS: 1400 N. Caroline Street

23C. DATE SIGNED: 2/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried

24B. DATE: 3/1/49

24C. NAME OF CEMETERY OR CREMATORY: St Augustines Cem.

24D. LOCATION (City, town, or county) (State): Elkridge Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 27 1949

REGISTRAR'S SIGNATURE: Signature for Williams M.D.

25. FUNERAL DIRECTOR: John J. Gowan & Son ADDRESS: 2 Collins St

Vs 150

Earl L. Royer - Asst. Med. Examiner 1240

G71948 G71958

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Katherine Broderick

2. DATE OF DEATH: 2/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jenkin's Memorial Hospital
c. Length of stay in Baltimore: 71 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 4804 Frederick Ave. Baltimore
C. CITY OR TOWN (If outside corporate limits, write R.F.D. and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 4804 Frederick Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W	2/14/79	71 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	None	Baltimore, Maryland	USA

13. FATHER'S NAME: Michael Mc Kew

14. MOTHER'S MAIDEN NAME: Marie Daley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Family	4804 Frederick Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		
(A)	Bronchopneumonia (Primary)	
DUE TO		
(B)	Arteriosclerotic C-V. Disease generalized	
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 14 1949 to Feb. 25, 1949 *that I last saw the deceased alive on* Feb. 24 1949, *and that death occurred at* 8 00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thos. E. Carr M.D.	St Agnes Hosp.	2/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county and State)
Burial	3/1/49	New Cathedral Cem.	4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 27 1949	Huntington Williams, M.D.	John J. Cowan & Son	901 Hollins St

VS 150

93D

ERTIFICATE CORRECTED 3-16-49

G71949 BALTIMORE CITY HEALTH DEPARTMENT G71949

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) Nelia Crocker

2. DATE OF DEATH 2/26/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 29 N Carey St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Home + Hospital

C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore Yrs. 2 Mos. 6 Days

D. STREET ADDRESS (If rural, give location) 1007 W Lombard St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If under 1 Year: Months Days	If under 24 Hours: Hours Min.
female	white		6/21/1876	72	8 1	

9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	9B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home.	Baltimore.	U S A

13. FATHER'S NAME John Daniel Fitzgerald

14. MOTHER'S MAIDEN NAME (Stationmore) Bridget Ryan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—	—	—	Mr William F. Crocker	2646 Huford Rd.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH**

I **DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial deterioration — INTERVAL BETWEEN ONSET AND DEATH: months

DUE TO

ANTECEDENT CAUSES

(B) Bronchitis — 2 years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

DUE TO

(C)

II **OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10/5/48, 19__, to 2/26, 19 49 *that I last saw the deceased alive on* 2/21/49 19__, *and that death occurred at* 5:30 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter J Conran M. D.	1012 Edmondson	2/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/28/49	New Cathedral Cem	4200 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 27 1949	Huntington Williams, M.D.	John J. Conran & Son	924 Eutaw St

93D.

CERTIFICATE CORRECTED 3-22-49

G71930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443 Registered No. G71930

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Pearl M. Cathey

2. DATE OF DEATH Feb 26, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hosp

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 25 25
D. STREET ADDRESS (If rural, give location) 4207 Maryland Court

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	2/4/69 81	68 (79)		

10A. USUAL OCCUPATION (Give kind of work done during greatest part of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cynthia Gilbreath

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Smith

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Simon Lukas ADDRESS 3459 Churchill Court

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

(B) Hypertensive cardio-vascular disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 7, 19 49, to Feb 26, 19 49, *that I last saw the deceased alive on* Feb 26, 19 49, *and that death occurred at* 10 15 m., *from the causes and on the date stated above.*

23A. SIGNATURE Philip G. Rabbitt M.D.

23B. ADDRESS 1400 N. Caroline St

23C. DATE SIGNED Feb 26, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 3/29/49

24C. NAME OF CEMETERY OR CREMATORY Anderson

24D. LOCATION (City, town, or county) Longfield (State) La

DATE RECEIVED BY LOCAL REGISTRAR FEB 27 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR William Cook Inc

ADDRESS 421 E Fayette St

93D

G71951 ✓ 610 G71951

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM B WASHINGTON

2. DATE OF DEATH: FEB. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME and HOSPITAL

c. Length of stay in Baltimore: LIFE 86 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2106 E. HOFFMAN ST. 8 04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
MALE	WHITE	MARRIED	JULY 24, 1862	86	7 0	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	Sales Man	MARYLAND	US

13. FATHER'S NAME: GEORGE WASHINGTON

14. MOTHER'S MAIDEN NAME: MARGARET CHAPMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
NO			~~Self~~ Mrs Emma A Washington 2106 E. Hoffman St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary Embolism, Right	minutes
	DUE TO Prostatectomy, Recent	
	Myocardial Degeneration	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C) Carcinoma of Colon	
	Hypertension, Chronic	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Cholecystitis & Cholelithiasis	years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
FEB. 24, 1949	SUPRA PUBIC PROSTATECTOMY	YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Jan 27, 1949, *to* Feb. 24, 1949, *that I last saw the deceased alive on* Feb 24, 1949, *and that death occurred at* 11:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Morrow M. D.	Church Home & Hospital	Feb. 25 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-28-49	Moreland Memorial	Taylor Ave Balto Co.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 27 1949	Huntington Williams, M.D.	George J. Ruth Inc.	1735 Hanford Ave

VS 150

46E

G71952 ✓ 33 G71952

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): George H.Trout.

2. DATE OF DEATH: Feb 25,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2606 Ken Oak Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2606 Ken Oak Rd. 2-9

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed.	Nov.6,1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired,Machinst	Penn.R.R.	Md.	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
-	-	-	Rae T.Phillipps.	2606 Ken Oak Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 wk

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral arteriosclerosis — —

DUE TO

(C) Generalized arteriosclerosis —

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Feb 6, 1949, *to* Feb 25, 1949, *that I last saw the deceased alive on* Feb 25, 1949, *and that death occurred at* 5:10 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Norman R. Freeman M. D.	11 W. 29th St.	Feb 26, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/28/49	Manchester.	Manchester Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 27 1949	Investigator Williams, M.D.	Paul E.Chenoweth Jr	3615-17 Chestnut Ave.

838

GM, 127087

G71953

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71953

Registered No.

1. NAME OF DECEASED (Type or Print) Evelyn Smith

2. DATE OF DEATH 2-26-1940

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 Eastern Ave Baltimore City Hospitals

C. Length of stay in Baltimore 6 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2003 Maryland Ave. Z 12 1-05

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M

8. DATE OF BIRTH May 24-1915

9. AGE (In years last birthday) 33 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) W. VA.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Edward Curry

14. MOTHER'S MAIDEN NAME Ethel Stewart (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS Records Balto. City Hospitals Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Of Liver. — DUE TO

(B) Fatty Infiltration — DUE TO

(C) Pulmonary [illegible] with Pleurisy — 10 Months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

[illegible] H. W. L.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-23-, 1940, to 2-26-, 1940, *that I last saw the deceased alive on* 2-26-1940 *and that death occurred at* [illegible] 2m., *from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M. D.

23B. ADDRESS B.C.H. 4940 Eastern Ave.

23C. DATE SIGNED 2-26-40

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE March 2

24C. NAME OF CEMETERY OR CREMATORY Glenberg W. Va

24D. LOCATION (City, town, or county) (State) Glenberg W Va

DATE RECEIVED BY LOCAL REGISTRAR FEB 28 1940

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR A. N. Carraccio

ADDRESS 1404 Ridge Ave

VS 150

13B

G719:54 BALTIMORE CITY HEALTH DEPARTMENT G719:54

CERTIFICATE OF DEATH 177

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mr. Edward L. Shipley
2. DATE OF DEATH: 2/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Uniontown, Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): (Rural) Uniontown
D. STREET ADDRESS (If rural, give location): Uniontown, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	White	married	Jan. 18, 1881	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farmer	Maryland	

13. FATHER'S NAME: Charles Shipley
14. MOTHER'S MAIDEN NAME: Sarah Dollinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
unknown		Mrs. Kirth Cross Shipley, Uniontown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of the Prostate c Metastasis — DUE TO — (INTERVAL BETWEEN ONSET AND DEATH) 18 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes Mellitus, pneumonia extensive

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES X NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Green, III M. D.	Union Memorial Hosp.	27 Feb 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	March 2-49	Kriders	Carroll Co.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 28 1949	Huntington Williams, M.D.	H. Bankard, Son Westminster Md

VS 150

510

G71955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G71955

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) MARY A MILLER

2. DATE OF DEATH 2-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland RAYNOR Ave + Dukeland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO. GEN. HOSP.

C. Length of stay in Baltimore 63 yrs 6 mos Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2751 W. Mosher St 16 06

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
F	W	WIDOWED	Oct 3, 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		New York	

13. FATHER'S NAME Dennis O'Neill

14. MOTHER'S MAIDEN NAME Ellen Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. O'Neill Miller	2751 W. Mosher St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Shock

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute myocardial infarction

DUE TO

(C) Arteriosclerotic CVD

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2/25/19 49 to 2/25/19 49, that I last saw the deceased alive on 2/25/19 49, and that death occurred at 8:00 P.M. from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	West Balto Gen Hosp	2/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-28-49	New Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 28 1949	Huntington Williams, M.D.	Harry H. Witzke	4101 Edmondson Ave

VS 150

93D

G71956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

150

G71956

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): IDA BERMAN

2. DATE OF DEATH: 2-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hebrew Aged Home, Levindale

C. Length of stay in Baltimore: 50 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Levindale Home

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Married M	1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Russia	USA

13. FATHER'S NAME: Israel Bucker

14. MOTHER'S MAIDEN NAME: Rachel Leah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Allen Berman ADDRESS: 1724 N Bentalou St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA ESOPHAGI — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Fibromyxoma of ovary

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-18 *,* 1948 *to* 2-27 *,* 1949 *, that I last saw the deceased alive on* 2-27 *,* 1949 *and that death occurred at* 7:45 a *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Nagel M.D.	Levindale Home	2-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-28-49	Sobroisker Circle	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 28 1949	Huntington Williams, M.D.	S. Levinson & Bros	1124 W North Ave

VS 150

46a

G71957

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E. 47-0

G71957

Registered No.

1. NAME OF DECEASED (Type or Print): Elsie Myrtle Smitzel — N-968-0

2. DATE OF DEATH: Feb. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived, If institutional: Last residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3505 Elmley Ave. 26 0 3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
F	W	Married	Nov. 11, 1907	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	US

13. FATHER'S NAME: Arthur T. Jones

14. MOTHER'S MAIDEN NAME: Mathilda Blak

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	213-05-8723	Joseph F. Smitzel	3505 Elmley Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation

DUE TO

(B) Carbon Monoxide Poisoning

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	3505 Elmley Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
2—25—49 ?p. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Four burners on but unlit

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Carl L Royer M D		2/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/28/49	Baltimore Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB 28 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC.	BALTIMORE - 13, MARYLAND

VS 151

162 H

G71958

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71958

1. NAME OF DECEASED (Type or Print): Walter Francis Snellings

2. DATE OF DEATH: Feb 26, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hosp.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1815 N. Chester St. 8 or

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9/26/89
9. AGE (In years last birthday): 59 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Penna. R.R.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Snellings
14. MOTHER'S MAIDEN NAME: Susan Little

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 717-07-8273
17. INFORMANT: Mrs. Louise E. Snellings 1815 N. Chester Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease (Cerebral Decomposition)
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Bleeding peptic ulcer

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 24, 19 49, *to* Feb. 26, 19 49, *that I last saw the deceased alive on* Feb 25, 19 49, *and that death occurred at* 2 01 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Phillip A. Peter M.D.
23B. ADDRESS: 1402 N Caroline St
23C. DATE SIGNED: Feb 26 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/28/49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Memorial
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: FEB 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND

117a

71959

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

177 Registered No. G71959

1. NAME OF DECEASED (Type or Print): ALBERT KAISS

2. DATE OF DEATH: 2/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSP
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2800 Annapolis Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Jan-17-1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Kaiss Land Co	Md.	USA

13. FATHER'S NAME: John Kaiss

14. MOTHER'S MAIDEN NAME: Maria Schultz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Mrs Minna L Kaiss	2800 Annapolis Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of Prostate	
DUE TO (B)	metastatic to brain	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/2, 1949 *to* 2/27, 1949, *that I last saw the deceased alive on* 2/27, 1949, *and that death occurred at* 8:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Nicholas Mc Aloon M. D.	University Hosp	2/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 2 1949	Loudon Park	Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 28 1949	Huntington Williams, M.D.	Henry Lenhardt & Son	North Ave & Broadway

VS 150

51 B

G71960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No.

G71960

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nora L Garrett

2. DATE OF DEATH: Feb. 25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1550 N Carey

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1550 N Carey — Baltimore

c. Length of stay in Baltimore: 16 Yrs. years, Mos. —, Days —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balt.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1550 N Carey St

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 1897
9. AGE (In years. last birthday): 51
If Under 1 Year: Months —, Days —
If Under 24 Hours: Hours —, Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Kyser W. Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Brady
14. MOTHER'S MAIDEN NAME: Annie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Pleasant Garrett
ADDRESS: 1550 N Carey

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio-Vascular Disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 14 1949 *to* Feb 25, 1949, *that I last saw the deceased alive on* Feb 25, 1949, *and that death occurred at* 10:05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. W. McDonald M. D.
23B. ADDRESS: 544 N Carey St
23C. DATE SIGNED: 2/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 1-1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: FEB 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Brooks
ADDRESS: 1463 N. Carey St

VS 150

939

G71961

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71961

1. NAME OF DECEASED (Type or Print): Frances Holmes — N-861

2. DATE OF DEATH: 2/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1508 Presstman St.
D. STREET ADDRESS (If rural, give location): Baltimore

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	C	Single	11/13/26	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Trucker	B&O R.R.	Baltimore	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Andrew Holmes	Jessie Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes		Andrew Holmes - 1508 Presstman

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Stab Wound of Heart	
	DUE TO (B)	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	street	Front of 1519 Biggs Ave.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
2-21-49 8:45 P. m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Sharp instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER [X] / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Emil Rupp, M.D.		2/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/28/49	Mt Auburn	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 28 1949	Huntington Williams, M.D.	Charles L. Law	802 Mad Ave

VS 151

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G71962

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 175

BIRTH NO. G71962 Registered No.

1. NAME OF DECEASED (Type or Print) JULIA A. BEVANS
2. DATE OF DEATH 2/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE Md
B COUNTY Balto Co
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) TOWSON
D STREET ADDRESS (If rural, give location) 515 E JOPPA ROAD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	W	WIDOWED	OCT 22 1869	79 80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		TOWSON	

13. FATHER'S NAME THOMAS BAYNE
14. MOTHER'S MAIDEN NAME MARY E. WRIGHT
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Mr John Bevans ADDRESS Christopher

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF OVARY & METASTASIS
DUE TO
(B) CACHEXIA & INANITION
DUE TO
(C) GEN'L ARTERIOSCLEROSIS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/13, 1949 *to* 2/26, 1949, *that I last saw the deceased alive on* 2/26, 1949 *and that death occurred at* 5:48 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE Dr. Lloyd W. Mintz M. D.
23B. ADDRESS Church Home
23C. DATE SIGNED 2/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE March 1, 49
24C. NAME OF CEMETERY OR CREMATORY Oakwood
24D. LOCATION (City, town, or county) Taylor Ave (State) Md

DATE RECEIVED BY LOCAL REGISTRAR FEB 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR L. HEEMANN & SON ADDRESS 6062 Harford Rd

VS 150

49a

G71963

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Orig. 1

Registered No. G71963

1. NAME OF DECEASED (Type or Print): Sidney Graham

2. DATE OF DEATH: 2/23/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 630 S. Fremount 21-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	Widowed	Jan 20. 1878	70	1	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary Sowell ADDRESS: 630 S Fremont Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiac.

DUE TO

(B) Pneumonia Bronchial

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 2/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: February 25. 49

24C. NAME OF CEMETERY OR CREMATORY: Mount Zion Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore County Maryland

DATE RECEIVED BY LOCAL REGISTRAR: FEB 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Joseph A Lively ADDRESS: 661 W Baltimore St.

VS 151

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G71964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G71964

1. NAME OF DECEASED (Type or Print): JOSEPH MYERS

2. DATE OF DEATH: 2/23/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: 35 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 640 W. Barre st

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	Col	married	8/20/1893	55	6 / 3	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	B&O. R.R	Charlestown. S.C.	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Narcissus Myers	640 W. Barre st

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chr. V. H. disease — INTERVAL BETWEEN ONSET AND DEATH: 7
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/10/49, *to* 2/23/49, *that I last saw the deceased alive on* 2/12/49, *and that death occurred at* 5:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. A. Taylor M. D.	1522 Harlem Ave	2/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	February 26, 1949	Mount Auburn Cem	Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 28 1949	Huntington Williams, M.D.	Joseph A. Lisky	661 W. Barre St

VS 150

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Medical Examiner's Case — Release approved by A. Adams

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1965 BIRTH NO. Nutter 44 Registered No. G71965

1. NAME OF DECEASED (Type or Print): Mrs. Ella Nutter
2. DATE OF DEATH: 2/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — St. Agnes
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days: —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write IN RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1810 N. Monroe St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed	9-14-1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Md	U.S.A.

13. FATHER'S NAME: George Hottes
14. MOTHER'S MAIDEN NAME: Mary Pfeiffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Congestive Failure

DUE TO

(B) Chronic Nephritis & Hypertension

DUE TO

(C) Arteriosclerotic C-V disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Fracture Left Hip

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFIED BY [illegible] M.D. MEDICAL EXAMINER

19A. DATE OF OPERATION: 1-27-49
19B. MAJOR FINDINGS OF OPERATION: Application of Rogers Indian W-L Splint
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident — Fracture Left Hip
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): At Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): At Home
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 24-1949 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Patient fell in back yard

22. I hereby certify that I attended the deceased from 1-26, 1949 to 2-26, 1949 that I last saw the deceased alive on 2-26, 1949, and that death occurred at 11:15 a.m., from the causes and on the date stated above.

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: St. Agnes, Mitchell
23C. DATE SIGNED: 2-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-1-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: FEB 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR — ADDRESS: John T. Stansbury 2310 Edmondson Ave.

VS 150

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G71966 BALTIMORE CITY HEALTH DEPARTMENT 592 G71966

BIRTH NO. CERTIFICATE OF DEATH 015 Registered No.

1. NAME OF DECEASED (Type or Print): MRS RUBY JONES

2. DATE OF DEATH: 2-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write R.F.D. and give township): Balto
D. STREET ADDRESS (If rural, give location): 1703 E Biddle

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	Col	M	?	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Iowa	U.S.A.

13. FATHER'S NAME: ? Perry

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): ? (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: [illegible] Maryland Ave ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) [illegible]
DUE TO
(B) Chronic nephritis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Intercurrent infection, [illegible]

INTERVAL BETWEEN ONSET AND DEATH: [illegible] 6 years / [illegible] / [illegible]

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-2-, 1948 *to* 2-26-, 1949, *that I last saw the deceased alive on* 2-26-, 1949 *and that death occurred at* 12:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[illegible] M. D.	Mercy Hospital	2-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/1/49	Arbutus Mem. Pk.	Arbutus - Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 28 1949	Tunstall for Williams, M.D.	Joseph L. Locke, Jr.	1304 N. Central Ave

VS 150

19

Dr. Harbold

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71967

BIRTH NO. 71967

1. NAME OF DECEASED (Type or Print): HARVEY V SWAIN

2. DATE OF DEATH: Feb. 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2702 Inglewood Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3023 Hamilton Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
male	white	married	Jan. 31, 1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Steel Worker

11. BIRTHPLACE (State or foreign country): Sharpsburg, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Swain

14. MOTHER'S MAIDEN NAME: Georgeanna Beshears

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: Mrs. Minnie Swain, 3023 Hamilton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — Interval between onset and death: 6 hrs

DUE TO

(B) Auricular Fibrillation — 6 months

DUE TO

(C) Acute myocardial insufficiency ? Generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 14, 1943 *to* Feb. 24, 1949 *that I last saw the deceased alive on* Feb. 24, 1949 *and that death occurred at* 4:50 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.: H. V. Harbold

23B. ADDRESS: 4706 Harford Road

23C. DATE SIGNED: 2-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-28-49

24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: FEB 28 1949

REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road.

VS 150

94a

671968

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

33 ✓ Registered No. 671968

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Laucht

2. DATE OF DEATH: 2-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1323 Elmtree St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months Days	If under 24 hours: Hours Min.
Male	White	W	May 2 1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Watchman	Drygoods Co	Balto. Md	

13. FATHER'S NAME: G. William Laucht

14. MOTHER'S MAIDEN NAME: Emma Von Lindesberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Mr. Chas. Laucht 1323 Elmtree St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Encephalomalacia

DUE TO

(B) cerebral arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Carl L Boyer M.D.		

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/1/49	Parkwood Cem	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
FEB 28 1949	Huntington Williams, M.D.	Leonard J. Kuck 5315 Harford Ave 14

VS 151

83c

G71969

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1942 G71969 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALBERT HESS

2. DATE OF DEATH 2-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai

C. Length of stay in Baltimore 9 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1625 Gwynn Falls Parkway 2/13-07

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH

9. AGE (In years last birthday) 66 If Under 1 Year: Months, Days. If Under 1 Day: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Moses

14. MOTHER'S MAIDEN NAME Yetta

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Bertha Hess ADDRESS 1625 Gwynn Falls Pkwy

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic & acute pulmonary edema

DUE TO Cardiac failure from arteriosclerotic and hypertensive cardiovascular dis.

(B)

DUE TO

(C) Chronic pyelonephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Benign prostatic hypertrophy

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-20, 1949, *to* 2-27, 1949, *that I last saw the deceased alive on* 2-27, 1949, *and that death occurred at* 9:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE H. Harris, M.D.

23B. ADDRESS Sinai Hospital

23C. DATE SIGNED 2-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 2-28-49

24C. NAME OF CEMETERY OR CREMATORY Rosedale

24D. LOCATION (City, town, or county) (State) Balto Md

25. FUNERAL DIRECTOR Jack Lewis Inc

ADDRESS 2100 Eutaw Pl

DATE RECEIVED BY LOCAL REGISTRAR FEB 28 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

VS 150

937

G71970

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1

G71970

Registered No.

1. NAME OF DECEASED (Type or Print) HARRY ALPERSTEIN

2. DATE OF DEATH 2-28-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Levindale

C. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1827 No Appleton St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Widowed		74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Russia	

13. FATHER'S NAME Meyer

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Reuben Alperstein	5713 Jonquil Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial fibrosis — INTERVAL BETWEEN ONSET AND DEATH: Few years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary sclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-12 1949 *to* 2-28 1949 *that I last saw the deceased alive on* 2-28 1949, *and that death occurred at* 12 45 *a* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Nagel M.D.	Levindale Home	2-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-1-49	B'nai Israel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 28 1949	Huntington Williams, MD	Jack Lewis Inc	2100 Eutaw Pl

VS 150

937

G7197 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G7197 1

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carrie Holland

2. DATE OF DEATH: February 26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1247 N. Bradford St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1247 N. Bradford St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1247 N. Bradford St. 6 03

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Mar. 14-1885	63	11 / 12	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Balto. Md.	

13. FATHER'S NAME: Scheffer

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Catherine Porter	2212 E. Fayette St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Chr. Nephritis + Chr. Myocarditis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Clin. Pul. TB. ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 16 19 49 *to* Feb. 26 19 49 *that I last saw the deceased alive on* Feb. 26 19 49 *, and that death occurred at* 7 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Howard Douglas M. D.	700 E. Baltimore St	2/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar. 1-1949	Balto. Cemetery	North Ave. + Gay St.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 28 1949	Carrington Williams, M.D.	John L. Miller	2334 Jefferson St.

VS 150

13B

6719.72

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

6719.72

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): SARAH BRITTON

2. DATE OF DEATH: February 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Soth Balto. General Hosp.
c. Length of stay in Baltimore: 20 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 642 Waltemeyer Court 14 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	Colored	married	June 4, 1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Va	

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		James Britton	642 Waltemeyer Ct

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pericarditis (pneumococcic)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George S. Merrill M.D.	[ ] / [X] / [ ]	2-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	march 1, 1949	Mt Calvary	md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 28 1949	Huntington Williams, M.D.	George G. Kelson	1303 Pennsylvania Ave

VS 151

90B

G71973

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71973

1. NAME OF DECEASED (Type or Print): Jacob Baynor

2. DATE OF DEATH: February 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 528 N. Vincent St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 528 N. Vincent St. 19 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	Colored	Widowed	Jan. 4, 1891	58	1 / 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Baltimore, Maryland	America

13. FATHER'S NAME: Lloyd Baynor

14. MOTHER'S MAIDEN NAME: Martha Blake

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mary Baynor ADDRESS: 1504 Argyle Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral Pulmonary Tuberculosis (Far Advanced) — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-5, 1949, *to* 2-26, 1949, *that I last saw the deceased alive on* 2-19, 1949 *and that death occurred at* 2:00 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard H. Hunt M. D.	1631 W. Franklin St.	2-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/2/49	Mt Auburn	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR ADDRESS
MAR 2 1949	Thurlington for Williams, M.D.	Geo. G. Kelson 1303 Presstman St.

VS 150

13B

719.74

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G71974

Registered No.

1. NAME OF DECEASED (Type or Print): MARIAN WILLIAMS

2. DATE OF DEATH: February 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

C. Length of stay in Baltimore: Yrs. 2 Mos. 0 Days 6

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3216 Remley Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
female	colored	i		57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H. W	—	Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Stansbury	Annie Hurst

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Thomas Williams	3216 Remley St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Myocardial Degeneration	
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Ernest L. Kaye M.D.		Feb. 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 28 1949	Mt Auburn Cem	B.A.Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 28 1949	Huntington Williams, M.D.	Isaac L. Brown Son	108 N Monty omery St

VS 151

9=D

G71975

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71975

1. NAME OF DECEASED (Type or Print): Anna V. Rossi

2. DATE OF DEATH: Feb 26-49

3. PLACE OF DEATH: a. Baltimore City, Maryland 516 S. Potomac St

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 32 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 1-02
d. STREET ADDRESS (If rural, give location): 516 S. Potomac St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	Married	May 25 1882	66	9 / 1	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Italy	U.S.A.

13. FATHER'S NAME: Dominick Falcone

14. MOTHER'S MAIDEN NAME: Mariadonata Falcone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: Thomas Rossi ADDRESS: 516 S Potomac St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — (Interval between onset and death): 30 minutes

DUE TO

ANTECEDENT CAUSES

(B) Coronary Arteriosclerosis — ?

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Generalized Senile Arteriosclerosis — ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* February 8, 1949 *to* February 26, 1949, *that I last saw the deceased alive on* Feb. 26, 1949, *and that death occurred at* 9:35 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Clarence W. LeDoux M. D.	3023 Eastern Ave.	2/26/49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	MARCH 1 1949	HOLY REDEEMER	4430 BELAIR RD MD.

DATE RECEIVED LOCAL REGISTRAR: FEB 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Diffpel Bros. ADDRESS: 1800 E LOMBARD ST

VS 150

94a

G719'6

JL- 85351

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G719'6

Registered No.

1. NAME OF DECEASED (Type or Print) Delores Dorsch, or Delores Bukauskas BUKAUSKAS

2. DATE OF DEATH Feb. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 722 W. Lexington St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	White	Married	June 3, 1925	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME Joseph Bukauskas

14. MOTHER'S MAIDEN NAME Marcella Sinkavicius

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Bilateral Tuberculosis for Advanced	1 Yrs.
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Addison Disease	6 Months

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 11, 1943, *to* Feb. 27, 1949, *that I last saw the deceased alive on* Feb. 27, 1949, *and that death occurred at* 9PM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. L. Rogers M. D.	B.C.H. 4940 Eastern Ave.	2-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	March 2 1949	Holy Cross Cem	Anne Arundel County

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 28 1949	Huntington Williams, M.D.	Joseph Kasmakas	602 Wash. Blvd

Correct age is especially important. Physicians please write plainly.

12R

G719.7 /81 G719.7

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): HARRY GEORGE ANTONE
2. DATE OF DEATH: 2/27/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 2321 N. Charles St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2321 N. Charles St.

5. SEX	6. COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
clerk	Md. Sec. Board	Baltimore	

13. FATHER'S NAME: George Antone
14 MOTHER'S MAIDEN NAME: Annie Heim

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
NO	—		Mr. H. Gibson Antone	412 Whitridge Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CARCINOMA BLADDER	6 MONTHS
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	I	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	ATHEROSCLEROTIC HEART DISEASE	3 MONTHS

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
NONE	NONE	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, public bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NONE	NO	NONE

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NONE WHILE NOT AT WORK ☐	21F. HOW DID INJURY OCCUR?
NONE m.		NONE

22. *I hereby certify that I attended the deceased from* JAN. 22, 1949 *to* FEB-27, 1949 *that I last saw the deceased alive on* FEB-27, 1949 *and that death occurred at* 5 25 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Elliot D. Lyday M.D.	24 E. 33rd St.	4/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/2/49	Druid Ridge Cem.	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
FEB-28-1949	Huntington Williams, M.D.	WIEDEFELD & SON	GREENMOUNT AVE & 22nd.

52B

6719.8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450.0

6719.8

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Edward E. Gleason

2. DATE OF DEATH: 2/27/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2713 Riggs Ave

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2713 Riggs Ave 16 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	white	Widowed	3/2/1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10B. KIND OF BUSINESS OR INDUSTRY: Baltimore City

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Philip Gleason

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: 2713 Riggs Ave Mrs Catherine E Gleason.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uraemia — (Interval between onset and death): 48 hrs.

DUE TO

(B) Chronic Nephritis — 3 years

DUE TO

(C) Arterio Sclerosis — 3 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Feb. 1st 1949 *to* Feb 27th 1949, *that I last saw the deceased alive on* Feb. 27th 1949 *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. J. McDermott M.D. M. D.

23B. ADDRESS: 1136 Poplar Grove St

23C. DATE SIGNED: 2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3/2/49

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR: FEB 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John J. Conway & Son — ADDRESS:

VS 150

131a

6719.9

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6719.9

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Murrel Conrad Hiteshue

2. DATE OF DEATH Feb. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Towson

c. Length of stay in Baltimore 7 Yrs. ___ Mos. ___ Days

D. STREET ADDRESS (If rural, give location) 615 East Joppa Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	married	Dec. 8, 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Steel & Derbies

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Penna

12. CITIZEN OF WHAT COUNTRY? Us

13. FATHER'S NAME Ernest Hitchens

14. MOTHER'S MAIDEN NAME Katherine Hakle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 176-01-3444

17. INFORMANT K. A. Keller ADDRESS Glen Rock, Pa

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute myocardial infarct	
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 21, 1949, to Feb 28, 1949, that I last saw the deceased alive on Feb 28, 1949, and that death occurred at 4:55 a.m., from the causes and on the date stated above.

23A. SIGNATURE John R. Smith, Jr. M. D. | 23B. ADDRESS Union Memorial Hospital - Balto. Md | 23C. DATE SIGNED 3-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24B. DATE 3/2/49 | 24C. NAME OF CEMETERY OR CREMATORY Lutheran | 24D. LOCATION (City, Town, or County) (State) Glen Rock Pa

DATE RECEIVED BY LOCAL REGISTRAR FEB 28 1949 | REGISTRAR'S SIGNATURE Huntington Williams, MD | 25. FUNERAL DIRECTOR H. Chapple ADDRESS Glen Rock Pa.

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G71980

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ X331 G71980

Registered No.

1. NAME OF DECEASED (Type or Print) FLORENCE OWINGS

2. DATE OF DEATH Feb. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTIMORE GEN. HOSPITAL

c. Length of stay in Baltimore: Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural--Westminster
D. STREET ADDRESS (If rural, give location)

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct. 5, 1881 | 9. AGE (In years last birthday) 67 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Philip Frick

14. MOTHER'S MAIDEN NAME Elizabeth Barnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT D. Carroll Owings, Westminster, Md. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CEREBRAL HEMORRHAGE
DUE TO
(B) HYPERTENSION
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/27/49 *to* 2/28/49, *that I last saw the deceased alive on* 2/28/49, *and that death occurred at* 4.00 Am., *from the causes and on the date stated above.*

23A. SIGNATURE Ross Rowland M. D. | 23B. ADDRESS WBGP | 23C. DATE SIGNED 2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 3-2-49 | 24C. NAME OF CEMETERY OR CREMATORY Deer Park | 24D. LOCATION (City, town, or county) (State) Smallwood, Carroll Co, Md.

DATE RECEIVED BY LOCAL REGISTRAR Feb 28 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25 FUNERAL DIRECTOR C. M. Waltz, Winfield, Md. ADDRESS

VS 150

83a

G71981

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

33 ✓ Registered No. G71981

1. NAME OF DECEASED (Type or Print): Margaret B. Klug

2. DATE OF DEATH: 2-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): TEMPLE GARDEN APTS 13-C-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
F	W	S	JAN. 26, 1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maid			

13. FATHER'S NAME: Wm B KLUG

14. MOTHER'S MAIDEN NAME: MARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr Wm KLUG ADDRESS 1335 TRINIDAD AVE D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: about 8 days

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-20-, 1949, to 2-26-, 1949 *that I last saw the deceased alive on* 2-26-, 1949, *and that death occurred at* 5:50 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. D. Thomas, Jr. M. D.	Mercy Hosp.	2-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	MARCH 1'49	ST MARY GERM. CATHOLIC	WASHINGTON. D.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1	Huntington, [illegible]	Henry H Wythe	1101 Edmondson Ave

VS 150

8

83C

G71982

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

177

X G71982

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK ALLMER TREZISE

2. DATE OF DEATH Feb. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: Yrs. 66 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pikesville
D. STREET ADDRESS (If rural, give location) 1707 Reisterstown Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Widower	11/13/73	75	3	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Md.	USA

13. FATHER'S NAME: John H. Trezise

14. MOTHER'S MAIDEN NAME: Margaret ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	SAW	?	Records- US Marine Hospital	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the prostate with widespread metastases

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Unknown

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Dec. 23, 1948, *to* Feb. 27, 1949 *that I last saw the deceased alive on* Feb. 27, 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	US Marine Hospital, Balto. Md.	2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/3/49	Mount Olivet	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	Huntington Williams, M.D.	Wilhelm & Son	1214 Park Ave

VS 150

51B

G71983

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G71983

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Horn

2. DATE OF DEATH: February 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elkins Nursing Home 2101 W. Cold Spring Lane

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1629 Aliceanna Street

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	single	Sept. 30, 1869	79	4	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farm hand		Germany	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		D.P.W. Records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CHRONIC MYOCARDITIS	2 yrs.
DUE TO (B)	ARTERIOSCLEROSIS	10 yrs
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-20, 1949, *to* 2-27-, 1949 *that I last saw the deceased alive on* 2-27, 1949, *and that death occurred at* 9 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Norman R. Kleiman M. D.	3833 Edmondson Ave	2-28-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	3/1/49	St. Peter's Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 1 1949	Henrietta Fox Williams	Wm. Cook, Inc., 1217 St. Paul Street

VS 150

93D

671984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 420.1

671984

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): LEO E. WEIDNER

2. DATE OF DEATH: Feb. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 410 Venable Avenue
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 410 Venable Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	Nov 26, 1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Groceryman	Grocery	Baltimore, Maryland	

13. FATHER'S NAME: Edward P. Weidner

14. MOTHER'S MAIDEN NAME: Marion Harist

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	World War I	None	Mr. Francis Gearhardt	410 Venable Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CORONARY THROMBOSIS	48 HRS.
DUE TO (B)	CORONARY ARTERIOSCLEROSIS	10 YRS.
DUE TO (C)	—	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	—	

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/14, 1948 *to* 2/26, 1949 *that I last saw the deceased alive on* 2/26, 1949 *and that death occurred at* 8:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm W Machen M. D.	6331 Belair Rd (6)	2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 1, 49	U.S. National	Baltimore 5501 Frederick Ave. Balto.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	Huntington Williams	William Cook, Inc.	1217 St. Paul Street

VS 150

94a

67 1945

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 1945

BIRTH NO.

1 NAME OF DECEASED (Type or Print) Claude T. Geare

2 DATE OF DEATH 2-27-49

3 PLACE OF DEATH: Baltimore City, Maryland

4 USUAL RESIDENCE (Where deceased lived If institution residence before admission)
A STATE Md.
B COUNTY

5 FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

C CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore

c Length of stay in Baltimore — Yrs. Mos. Days

D STREET ADDRESS (If rural, give location) 1017 Brentwood Ave.

5 SEX	6 COLOR OR RACE	7 SINGLE MARRIED WIDOWED DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	Married	[illegible], 1904	44		

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country)

12 CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME Frederick Geare

14 MOTHER'S MAIDEN NAME Willet Kidwell

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16 SOCIAL SECURITY NO.

17 INFORMANT ADDRESS

MEDICAL CERTIFICATION

18 CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)

(A) Retro-Sternal C.V. Disease

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(C)

(D)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES NO X

21A EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH

21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (Month) (Day) (Year) (Hour)

21E INJURY OCCURRED WHILE AT WORK? WHILE NOT AT WORK?

21F HOW DID INJURY OCCUR?

22 *I certify that I took charge of the remains described above, held an* Inspection & In. (Autopsy, Inspection or Inquiry) *the case and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐*

23A SIGNATURE Emil L. Beyer M.D.

23B CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR X

23C DATE SIGNED 3-7-49

24A BURIAL, CREMATION, REMOVAL (Specify) Burial

24B DATE 3-2-49

24C NAME OF CEMETERY OR CREMATORY

24D LOCATION (City, town or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR MAR 7

REGISTRAR'S SIGNATURE

25 FUNERAL DIRECTOR

ADDRESS

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

71986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 71986

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William H. D. Hesterberg

2. DATE OF DEATH Feb. 26-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 921 DE Soto Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	4-1-1871	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Butcher	Meat Cutter	Maryland	USA.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME Johanna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	None	Samuel J. Hesterberg	2540 W. Baltimore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aneurism of the arch of the aorta

DUE TO —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO —

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1949 to Feb 24, 1949 that I last saw the deceased alive on Feb 24, 1949, and that death occurred at ____ m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas S. Bowers	221 Medical Arts Bldg	3/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar. 1-49	Loudon Park	Balto. City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	Huntington Williams, III	F. B. Wippert's Son	130 Eutaw St.

VS 150

30

G71987

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1948 G71987 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LAWRENCE BATES CHILDS
2. DATE OF DEATH: Feb. 28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2967 Keswick Rd
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 63 yrs Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore B. COUNTY City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give box No.) 2967 Keswick Rd 13-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	married	[illegible] 79	71	9	1

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant	Grocer	Baltimore County	U.S.

13. FATHER'S NAME: Thomas Childs
14. MOTHER'S MAIDEN NAME: Bond Balto. County

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		no

17. INFORMANT: Grace B. Childs ADDRESS: 2967 Keswick Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Stomach — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO Infiltrating Duct and diaphram
(B)
DUE TO
(C) Physical Exhaustion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Dec. 28/48	Spreading Cancer	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 1, 1948 *to* Feb. 28, 1949, *that I last saw the deceased alive on* Feb. 28, 1949, *and that death occurred at* 4:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sherwood Wantz M. D.	2601 Manhattan Ave	2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 2/49	Grave Run	Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	[illegible] Williams, M.D.	Austin E. Brogan	3638 Poland ave.

VS 150

46 B

#1988

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

42-1 G71988 Registered No.

1. NAME OF DECEASED (Type or Print): Florence M. Dougherty

2. DATE OF DEATH: 2/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 321 S. Collins Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 321 S. Collins Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	W.	Widow	March 18/72	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H. W.	None	Baltimore, Md.	

13. FATHER'S NAME: Frank Hawkins

14. MOTHER'S MAIDEN NAME: Georgianna Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Raymond Dougherty,	S. Carrollton AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Thrombosis	7 hrs.
DUE TO (B)	Chronic Myocarditis	5 yrs.
DUE TO (C)	Arteriosclerosis	?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1943 *to* 2/27 1949 *that I last saw the deceased alive on* Feb 25 1949 *and that death occurred at* 5:0a *m., from the causes and on the date stated above.*

23A. SIGNATURE: Albert H Carruthers M. D.
23B. ADDRESS: 4709 Hurd ave
23C. DATE SIGNED: 2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/2/49
24C. NAME OF CEMETERY OR CREMATORY: London Pk., 3801 Frederick Rd.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949
REGISTRAR'S SIGNATURE: Registrar for Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Wittstadt
ADDRESS: 4101 Edmondson Ave.

VS 150

93D

G71989

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 193

G71989

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carl Biggus

2. DATE OF DEATH: 2-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIV. Hosp.

c. Length of stay in Baltimore: 19 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: FREDK
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Frederick Md.
D. STREET ADDRESS (If rural, give location): Route #1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	M	1897	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Farm	Md.	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
UNKNOWN			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Left Femur Fracture

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
2-21-49	Left Femur Fracture	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-9 *, 1949, to* 2-28 *, 1949, that I last saw the deceased alive on* 2-28 *, 1949, and that death occurred at* 9:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
K. G. Fowler Jr. M. D.	Univ. Hosp.	2-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 3	Olds Fields	Westernport

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	Huntington Williams, M.D.	G C Barton	Walkersville

VS 150

54a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G71990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1

G71990 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MINNIE GERLACH

2. DATE OF DEATH: Feb. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1835 E. 30th St.

c. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1835 E. 30th St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
female	white	married	March 31, 1978	70 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	

13. FATHER'S NAME: George Hummel

14. MOTHER'S MAIDEN NAME: Lena Schnabel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no	Mr. J. H. Charles Gerlach	1835 E. 30th

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

DUE TO

(B) Diabetes mellitus — 15 years
Coronary Sclerosis
Generalized arterio sclerosis
Hypertension

DUE TO

(C) Nephritis Chronic Glomerular — 6 months
Right Hemiplegia
Edema & Pulmonary
Pulmonary and Ascites

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Febr. 1, 1949, *to* Feb. 26, 1949, *that I last saw the deceased alive on* Feb. 26, 1949, *and that death occurred at* 10:24 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter A. Anderson M. D.	300 Shannon Drive (3)	2-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
burial	3/1/49	Parkwood Cem.	Balto., Md.

DATE RECEIVED BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	Huntington Williams, M.D.	W.M. J. TICKNER & SONS	Balto., Md.

VS 150

61

Correct age is especially important. Physician please write the causes of death clearly and legibly.

G71991

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 196

G71991

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): REUBEN HOLMES WILBUR

2. DATE OF DEATH: Feb. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3511 Copley Rd.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 3511 Copley Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
male	white	widowed	Nov. 1, 1861	87 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		Baltimore, Md.	

13. FATHER'S NAME: Harrison O. G. Wilbur

14. MOTHER'S MAIDEN NAME: elina Ryland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Mr. Otis G. Wilbur	3511 Copley Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Superior Mediastinal Syndrome & respiratory failure	2 weeks
DUE TO, OR AS A CONSEQUENCE OF (B)	metastatic Carcinoma of lungs & mediastinum	?
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)	Carcinoma of Left neck & pectoral region - ? primary. Acute Chronic Endo-myocarditis	3 yrs more than five months
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 1948 *to* Feb. 26, 1949, *that I last saw the deceased alive on* 2/26, 1949, *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Maurice E. Shamer M.D	3 East N. Mt. Ave	3/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/1/49	Lorraine Cem.	Govdtown, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

55 K

collect age is especial, important. Physician please write the cause of death clearly and legibly.

67192 ✓ 33 ✓ 67192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LUDWIG MEIER | 2 DATE OF DEATH 26 FEB 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN. HOSP
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE MARYLAND
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D STREET ADDRESS (If rural, give location) 3718 CLAREMONT ST

5. SEX	6 COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	JULY 26, 1865	83	7 / 0	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
BUTCHER	MEAT	GERMANY	✓

13. FATHER'S NAME DONT KNOW

14 MOTHER'S MAIDEN NAME DONT KNOW

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
NO			MRS CAROLINE MEIER.	3718 CLAREMONT.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CEREBRAL THROMBOSIS - LEFT PARIETAL LOBE	3 wks
DUE TO (B)	GENERALIZED ARTERIOSCLEROSIS	?
DUE TO (C)	BRONCHOPNEUMONIA, BILATERAL	2 wks
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	PORTAL CIRRHOSIS	?
	DIABETES MELLITUS	?

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 10 FEB, 1949 *to* 26 FEB, 1949 *that I last saw the deceased alive on* 26 FEB, 1949 *and that death occurred at* 10 45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Donald I. Engyland M. D.	Maryland Gen Hosp	26 FEB 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, Town, or County) (State)
Burial	Mar 1 49	Oak Lawn	Balto Co

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	Remington for Williams, M.D.	Welsh Funeral Home	2008 Orleans

VS 150

61

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

(#7193 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

(#7193 Registered No.

1. NAME OF DECEASED (Type or Print): John Strobel

2. DATE OF DEATH: Feb. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 34 N. Streeper St.,

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 55 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 34 N. Stre per St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	White	Married	Aug. 27, 1875	73	3	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Iron moulder	Iron foundry	Germany	

13. FATHER'S NAME: Don't know

14. MOTHER'S MAIDEN NAME: Don't know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Miss Margaret Strobel	34 N Streeper St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Starvation — 5 days
DUE TO
(B) Carcinoma Supper Throat - originating in upper Oesophagus
DUE TO
(C) (One year)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
none	none	none

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	none	none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
none m.	none	none

22. *I hereby certify that I attended the deceased from* Feb 1 1949 *to* Feb 26, 1949 *that I last saw the deceased alive on* 1:30 PM Feb 26 1949 *and that death occurred at* 1:30 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. H. Kelly M. D.	100 N Linwood Ave	Feb 28 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar. 1, 1949	Parkwood	Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	Huntington Williams, M.D.	Ullrich Funeral Home	2008 Orleans St.,

VS 150

46a

Please write the cause of death clearly and legibly. Physician: Please write the cause of death clearly and legibly. Exact age is especially important.

BIRTH NO. 7194

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 7194

1. NAME OF DECEASED (Type or Print): M. ALICE SHAW
2. DATE OF DEATH: 2/27/49
3. PLACE OF DEATH: Baltimore City, Maryland
a. FULL NAME OF HOSPITAL OR INSTITUTION: (If not in hospital or institution, give street address or location) 1617 N. Caroline street
c. Length of stay in Baltimore: Lifetime (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1617 N. Caroline street
5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 9/10, 1882
9. AGE (In years last birthday): 66 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Gilles J. Shaw
14. MOTHER'S MAIDEN NAME: Mary E. Garrett
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mrs. Annie M. Warren ADDRESS: 2757 The Alameda

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ARTERIOSCLEROSIS — INTERVAL BETWEEN ONSET AND DEATH: 10 YRS
DUE TO
(B)
DUE TO
(C) FIXED ARTHRITIS. — 5 YRS.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 23, 1949, *to* Feb 27, 1949, *that I last saw the deceased alive on* Feb 27, 1949, *and that death occurred at* 8.00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: James F Kavanagh M.D.
23B ADDRESS: 3014 Mc Elderry St
23C DATE SIGNED: 3-1-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/3/49
24C NAME OF CEMETERY OR CREMATORY: New Cathedral
24D LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949
REGISTRAR'S SIGNATURE: Acting for Registrar
25 FUNERAL DIRECTOR: Chas. G. Evans & Son, Inc.
ADDRESS: 59B 118 N. Mt. Royal Ave.

VS 150

collect age is especially important. Physicians please write the cause of death clearly and legibly.

G71995 Hal 5

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 no. 1

G71995 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frank Skalinski

2. DATE OF DEATH FEB 27 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1623 Eastern Ave 2 0 3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	White	Widowed	11-22-78	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Vincent Skalinski
14. MOTHER'S MAIDEN NAME Marcella Jasinski
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cardio-respiratory failure	30 MINS
DUE TO (B)	Acute myocardial infarction	30 hrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Coronary arteriosclerosis	20 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Probably Carcinoma of Stomach	18 mos

19A. DATE OF OPERATION NONE
19B. MAJOR FINDINGS OF OPERATION NONE
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-17- 1949 *to* 2-27- 1949, *that I last saw the deceased alive on* 2-27- 1949, *and that death occurred at* 3 30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE M. J. Edgerton M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 2-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 3/2/49
24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 1 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR ADDRESS Wm. L. Fiallkowski 2007 Eastern Ave

VS 150

94a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

401824

BIRTH NO. 71996

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 71996

1. NAME OF DECEASED (Type or Print): Aurora M. Cammarata

2. DATE OF DEATH: FEB 27 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 26 years

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN, (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1817 Ashburton St.

5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 2-8-1916
9. AGE (In years last birthday): 33
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Savings Teller
10B. KIND OF BUSINESS OR INDUSTRY: Md. Trust Co.
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Cammarata
14. MOTHER'S MAIDEN NAME: Annette Mattei

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Polycystic Kidneys, congenital
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-7- 1949 *to* 2-7- 1949, *that I last saw the deceased alive on* 2-27- 1949 *and that death occurred at* 3:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: William L. Hartmann
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: Feb 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-3-49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. J. Tickner & Sons
ADDRESS: Balto. Md.

VS 150

1338

Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G71997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G71997

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JENNIE PLIMACK

2. DATE OF DEATH: 2-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Mount Sinai
C. Length of stay in Baltimore: 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2200 Park Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 78 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Benjamin
14. MOTHER'S MAIDEN NAME: Jessee
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Merrill Plimack ADDRESS: 2905 Edgewood Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute Cerebral Embolism
DUE TO
(B) Acute Embolism Left leg
DUE TO
(C) Ch coronary artery disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
Ch Hypertension

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/21 1948 to 2/28 1949 that I last saw the deceased alive on 2/28 1949 and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Ash Hornstein M. D.
23B. ADDRESS: 204 E Biddle St
23C. DATE SIGNED: 3/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-2-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Levin Inc ADDRESS: 2100 Eutaw Pl

VS 150

94a

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

1998

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E-5-3-4
N-8-3-2

Registered No. 1998

1. NAME OF DECEASED (Type or Print): Julius Goodman

2. DATE OF DEATH: 2-28-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-01

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial

D. STREET ADDRESS (If rural, give location): 2415 Brookfield Ave

c. Length of stay in Baltimore: 50 Yrs. / Mos. / Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	1-3-1888	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Moving Picture Owner

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Morbus

14. MOTHER'S MAIDEN NAME: Lena

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ella Goodman 2415 ADDRESS: Brookfield Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed Skull

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Jones Falls

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 29th St. Jones Falls Bridge 1/3/1

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 28 Feb 49 6:30 P. m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?: Car skidded on ice went off Bridge

22. *I certify that I took charge of the remains described above, held an* Autopsy / Inspection / Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ / ASSISTANT MEDICAL EXAMINER ☒ / MEDICAL INVESTIGATOR

23C. DATE SIGNED: 1 Mar 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3-1-49

24C. NAME OF CEMETERY OR CREMATORY: Mishkin Israel

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Jack Lewis Inc

ADDRESS: 2100 Eutaw Pl

VS 151

170c

Please write clearly and legibly. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

67999 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

67999 Registered No.

1. NAME OF DECEASED (Type or Print) HENRY SCHLICHTHORN

2. DATE OF DEATH March 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore, (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 2006 Wilhelm Street 20-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Male	White	SINGLE	Sept. 6, 1888	60	5 / 17	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook	ST. AGNES HOSP.	MARYLAND	U.S.A.

13. FATHER'S NAME William Schlichthorn

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
yes	World War I		Elizabeth Kanely	2006 W. Wilhelm St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary artery disease	
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED March 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	3-5-49	NEW CATHEDRAL	BALTIMORE, Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 4 1949	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
	[signature]	Geo. L. Schwab	2101 Frederick Ave.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Examine the certificate after it is written and make sure that the information is complete and correct and legible. Be especially careful to see that the cause of death is correctly stated. Any physician who refuses or neglects to sign a certificate of death or who certifies to the cause of death without sufficient knowledge of the facts, or who knowingly certifies to a false statement, is guilty of a misdemeanor and subject to a fine of not more than $100.00. Please write clearly and legibly. Physicians: please write the cause of death clearly and legibly.

94a

G72000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72000 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Richard A. Kirchner

2. DATE OF DEATH: 2/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto General Hospital
C. Length of stay in Baltimore: LIFETIME (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Anne A
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Greenhaven Md
D. STREET ADDRESS (If rural, give location): 5th St and Outing Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	W	M	1/27/1872	76	7	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TAILOR
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): TBALTO
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: FRED KIRCHNER
14. MOTHER'S MAIDEN NAME: CHRISTINA GERBIG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: LOUISE KIRCHNER ADDRESS: 5TH+OUTING AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C.V. Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: J. J. Sulewski M.D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	3/3/49	LOUDON PK CEMETERY	FREDERICK AVE

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949
REGISTRAR'S SIGNATURE: Awaiting for Information
25. FUNERAL DIRECTOR: GEO. H. LEIMBACH JR ADDRESS: N. LYNDHURST

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

93D

G72001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72004

BIRTH NO. ____ Registered No. ____

1. NAME OF DECEASED (Type or Print): Mr. William W. Woollcott

2. DATE OF DEATH: February 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE: Maryland; B. COUNTY: Baltimore; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville - Balto 28; D. STREET ADDRESS (If rural, give location): 116 Woodlawn Ave (Catonsville)

3B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital - 33rd & Calvert Sts.

3C. Length of stay in Baltimore: Yrs. ____ Mos. ____ Days ____

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 24, 1876

9. AGE (In years last birthday): 72 — If Under 1 Year: Months ____ Days ____ — If Under 24 Hours: Hours ____ Min. ____

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: ____

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Walter Woollcott

14. MOTHER'S MAIDEN NAME: Frances Bucklin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): ____

16. SOCIAL SECURITY NO: ____

17. INFORMANT: Marie Woollcott - (Wife) ADDRESS: ____

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 40 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary occlusion

DUE TO

(C) ____

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Edema

19A. DATE OF OPERATION: ____

19B. MAJOR FINDINGS OF OPERATION: ____

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ____

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): ____

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): ____

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: ____ m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?: ____

22. *I hereby certify that I attended the deceased from* Feb. 22, 1949, *to* Feb. 28, 1949, *that I last saw the deceased alive on* Feb. 28, 1949, *and that death occurred at* 7:42 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Frank Supplee, III, M. D.

23B. ADDRESS: Union Memorial Hosp

23C. DATE SIGNED: Feb 28 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 3/2/49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Balto, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949

REGISTRAR'S SIGNATURE: Thurston for Williams, Mgr

25. FUNERAL DIRECTOR: Wm J. Pickner & Sons

ADDRESS: Balto, Md.

VS 150

94 a

G72003 — BALTIMORE CITY HEALTH DEPARTMENT — G72002

BIRTH NO. — CERTIFICATE OF DEATH — Registered No. 41

1. NAME OF DECEASED (Type or Print): Elsie Dixon

2. DATE OF DEATH: Feb. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: 6 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1034 W. Franklin St. 18 W

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Married	2/15/1910	39 38				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H W		SC	

13. FATHER'S NAME: William Harris

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			James Dixon	1034 W Franklin St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchial Asthma — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B) — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection or Inquiry *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED: 2/26/1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal | 24B. DATE: 3/1/49 | 24C. NAME OF CEMETERY OR CREMATORY: Hamming SC | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Isaac L Bram Son | ADDRESS: 1048 Montgomery St

VS 151

PLEASE WRITE PLAINLY, with ink or indelible pencil. Physician please write the cause of death clearly and correct age is especially important.

112

BIRTH NO. 2003 127157

1342 X

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E954

Registered No. 2003

1. NAME OF DECEASED (Type or Print): Phillip Moore

2. DATE OF DEATH: 2- 26- 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6003 Baltimore Rd. Z 23

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	W	Dec. [illegible] 1927	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		VA.	

13. FATHER'S NAME: Phillip Moore

14. MOTHER'S MAIDEN NAME: Margaret

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records Dept. City Hospitals	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Probable Procaine sensitivity	
	DUE TO Pulmonary edema	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Epidural & Spinal Abscess	5days
	DUE TO CERTIFICATION APPROVED BY	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) For Wm. G. Hulbrich M.D. CHIEF OR ASST. MEDICAL EXAMINER	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
accident	hospital	4940 Eastern Ave. Baltimore City Hosp.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
2 26 49 7p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Procaine anesthesia injection

22. *I hereby certify that I attended the deceased from* 2- 26- 1949 *to* 2- 26- 1949, *that I last saw the deceased alive on* 2- 26- 1949 *and that death occurred at* 6:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M.D.	4940 Eastern Ave. Balto.	2- 27- 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/2/49	Mt Auburn Cemt	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	Huntington Williams, M.D.	Isaac L. Brown Son	1045 Montgomery St

VS 150

To Be Approved By [illegible]

179x

PLEASE WRITE PLAINLY, with ink. Physicians: please write the cause of death so that the correct age is especially important.

6-7/2004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

Registered No. 6-7/2004

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rebecca E. Davis

2. DATE OF DEATH: 2-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 467 Watty Court

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 467 Watty Court

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	Col.	Widow	Oct 12, 1899	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Savannah Ga.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Phillip Hart	Louise ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No.			Lottie Hales 1109 Tiffany Court

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cyst of
DUE TO Hypotension
DUE TO Hemiplegia of the right side

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: Duration Unknown

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
CERTIFICATION APPROVED BY
AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	[illegible] M. D.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY occur? [illegible] MEDICAL EXAMINER.
m.		

22. I hereby certify that I attended the deceased from [illegible] on 2-26-49, 19__, that I last saw the deceased on 1944 19__, and that death occurred at 10 P. m., from the causes and on the date stated above.

22A. SIGNATURE	22B. ADDRESS	22C. DATE SIGNED
W. K. Barksdale M. D.	526 W. Coley St. C.K.	By Mail 2-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 3, 1949	Mt Zion	Landsdowne Baltimore Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	[illegible] Williams, M.D.	Mrs Katie R. Williams	322 N Schroeder St

VS 150

83a

PLEASE WRITE PLAINLY, with [illegible] correct age is especially important. Physician: please write the cause [illegible] of death exactly, and

G#2005

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 20.0

G#2005

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Charles Thomas Carroll

2. DATE OF DEATH 2.27.49

3. PLACE OF DEATH: Baltimore City, Maryland 1326 Mosher St

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

b. Length of stay in Baltimore 60 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1326 Mosher St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md
D. STREET ADDRESS (If rural, give location) 1326 Mosher St. 16 or

5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH June 10, 1880 | 9. AGE (In years last birthday) 68 | If Under 1 Year Months Days | If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY Livery Stable

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Emory Carroll

14. MOTHER'S MAIDEN NAME Sarah Rowland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO Not Known

17. INFORMANT Margaret Elizabeth Carroll ADDRESS Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: about 2 mos

DUE TO

(B) Arteriosclerotic Heart Disease — ?

DUE TO

(C) Generalized Arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Malnutrition — ?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12.13.48, 19__, *to* 2.27.49, 19__, *that I last saw the deceased alive on* 2.25.49 19__ *and that death occurred at* 8:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE James M. Pair M.D. | 23B. ADDRESS 400 N. Carrollton Ave | 23C. DATE SIGNED 2.28.49

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried | 24B. DATE Mar 3, 1949 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Zion | 24D. LOCATION (City, town, or county) (State) Lansdowne, Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 1 1949 | REGISTRAR'S SIGNATURE Thurlington Williams M.D. | 25. FUNERAL DIRECTOR Mrs Katie R Williams | ADDRESS 322 N Schroeder

VS .150

937

PLEASE WRITE PLAINLY. Physicians: please write the cause of death in such terms as will convey the correct age is especially important.

G72006 ✓ 490 G72006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edith Carter

2. DATE OF DEATH: 2/26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 703 N. Carrollton Ave
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE
B. COUNTY: 703 Carrollton Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 703 N Carrollton Ave 18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col	Married	March 4, 1914	34		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machine Operator	Factory	Balto Md.	U.S.A.

13. FATHER'S NAME: William T Moody
14. MOTHER'S MAIDEN NAME: Agnes Hollie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No.		

17. INFORMANT: William T. Moody ADDRESS: 703 N. Carrollton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/2, 1949 to 2/26, 1949 that I last saw the deceased alive on 2/26, 1949, and that death occurred at 6.45 PM., from the causes and on the date stated above.

23A. SIGNATURE: B M Rhutta M. D.
23B. ADDRESS: 2134 D St
23C. DATE SIGNED: 2/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Mar 2, 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Mrs Katie R. Williams ADDRESS: 322 N Schroeder St

PLEASE WRITE PLAINLY. Physician: please write the cause of death in terms of disease and correct age is especially important.

VS 150

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67207 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

143 — Registered No. 67207

1. NAME OF DECEASED (Type or Print): GEORGE H. MORGERETH

2. DATE OF DEATH: 2-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltim
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp. & Monument & Rutland Ave
c. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Baltim
B. COUNTY: Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 512 S. Glover St — 1-03

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 23 1887
9. AGE (In years last birthday): 61 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gas & Electric Co
10B. KIND OF BUSINESS OR INDUSTRY: Metal Refining
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?: Yes
13. FATHER'S NAME: Henry Morgereth
14. MOTHER'S MAIDEN NAME: Elizabeth Brenner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 212-05-3934
17. INFORMANT — ADDRESS: Ella E. Morgereth 512 S Glover St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
(C)
Pulmonary embolism, Aortic Stenosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-21-45 *1949, to* 2-28 *, 1949, that I last saw the deceased alive on* 2-28 *, 1949, and that death occurred at* 8:45 *A m., from the causes and on the date stated above.*

23A SIGNATURE: Jerome Gaber M. D.
23B ADDRESS: Sinai Hosp
23C DATE SIGNED: 2-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 4 1949
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cem
24D LOCATION (City, town, or county) (State): Gaman Mill Road

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: John C. Moran 7000 Baltimore St

VS 150

92a

PLEASE WRITE PLAINLY, with pencil or pen. Physician: please write the cause of death clearly and correct age is especially important.

GN. 117614

G72008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G72008

1. NAME OF DECEASED (Type or Print) Rita Sweet

2. DATE OF DEATH 2- 28- 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1222 S. Kenwood Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	M	June [illegible] 1922	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frank Gralowski

14. MOTHER'S MAIDEN NAME Rose Stefanski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS Mrs. Stefanski

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Miliary Pulmonary tuberculosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 2 Months

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2- 12- , 19 49 *to* 2- 22- , 19 49, *that I last saw the deceased alive on* 2- 27- , 19 49 *and that death occurred at* 9.15 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M. D.

23B. ADDRESS B.C.H. 4940 Eastern Ave.

23C. DATE SIGNED 2- 28- 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 3/1/49

24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.

24D. LOCATION (City, town, or county) (State) Dundalk Ave

DATE RECEIVED BY LOCAL REGISTRAR MAR 1 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR INC ADDRESS STEPHEN J. FILAKOWSKI 1000 S. KENWOOD AVE

VS 150

PLEASE WRITE PLAINLY, with ink. Correct age is especially important. Physician: please write the cause of death clearly and

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G72009

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-21-1 Registered No. G72009

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annjeanette Bright

2. DATE OF DEATH: Feb. 28/49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashburton Nursing Home 3520 Hilton Road

c. Length of stay in Baltimore: 68yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Baltimore Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
d. STREET ADDRESS (If rural, give location): 2030 Jefferson St.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Sept. 20, 1862	86	5 / 8	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
---	----	Annapolis Md.	

13. FATHER'S NAME: Wm. Holidayoke

14. MOTHER'S MAIDEN NAME: Sarah J. Hook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
--	--	---	Miss Edna Bright	2030 Jefferson St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	8 weeks
DUE TO (B)	Arteriosclerosis	3 yrs
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1925, *to* Feb 28, 1949, *that I last saw the deceased alive on* Feb 27, 1949, *and that death occurred at* 10:20 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Michael A Abrams M. D.	1820 Eutaw Place	March 1, 49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	March 3, 1949	St. Ann's Episcopal Cem.	Annapolis Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	[illegible]	Philip Herwig Sons,	2024 Orleans S

VS 150

94a

PLEASE WRITE PLAINLY; please write the cause of death exactly as it should appear on the permanent record. Physician: please write the cause of death exactly as it should appear on the permanent record. Exact age is especially important.

G72010

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59 ✓ Registered No. G72010

BIRTH NO.

1. NAME OF DECEASED (Type or Print): IDA E. BARRACCA
2. DATE OF DEATH: February 28 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2356 Lehman St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W		November 16/20	28	3	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor	Tailor Shop	Brooklyn N.Y.	

13. FATHER'S NAME: Joseph Barracca
14. MOTHER'S MAIDEN NAME: Sarah Sessa ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	220-03-3967	Beny Barracca	2117 E. North Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	14 months
DUE TO (B)	Chronic Glomerular Nephritis	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Terminal Bronchopneumonia	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22 *I hereby certify that I attended the deceased from* January, 1928, *to* February 28, 1949, *that I last saw the deceased alive on* 2/28, 1949, *and that death occurred at* 4.00 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bobby L. Jones M. D.	Franklin Square Hosp.	2 28 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 2/49	Holy Redeemer Cem.	Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	[illegible]	Frank Della Rose	322 S. High St.

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and correct age is especially important.

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G7201.1 VANE ✓ X G7201.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

330 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Vane

2. DATE OF DEATH: 2-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Howard Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellicott City
D. STREET ADDRESS (If rural, give location): Columbia Pike

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital Redwood & Greene Sts

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	3/14/10	38	11 / 11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No	None	Roland R. Vane Ellicott City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid Hemorrhage
DUE TO
(B) Syph. Aneurism
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 Hours (6 PM to 10 PM)

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/25, 1949 *to* 2/25, 1949, *that I last saw the deceased alive on* 2/25, 1949 *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank E Brunback M. D.	University Hosp. Balto Md.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	3/2/49	London Park	Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
MAR 1 1949		Easton Sons Catonsville Md.

PLEASE WRITE PLAINLY, with pen or pencil; please write the cause of death clearly and correct age is especially important. Physician:

VS 150

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G7201 2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

493

Registered No. G7201 2

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES SNOWDEN

2. DATE OF DEATH: Feb. 22 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1205 Oakland Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Colored		7-28-04	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Nelson Snowden

14. MOTHER'S MAIDEN NAME: Sara Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
				JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

PLEASE WRITE CLEARLY, USING INK. Physician: please write the cause of death clearly and correct age in especially important.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia and septicemia, type I pneumococcus — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 2/27, 1949 *to* 2/27, 1949, *that I last saw the deceased alive on* 2/27, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Gordon Cader M. D.	JOHNS HOPKINS HOSPITAL	2/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-1-49	Mt Calvary Cem.	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	Theodore Hoffmann	Elroy O. Welton	1000 Broadway

VS 150

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G72013 CERTIFICATE CORRECTED 3-7-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 470.1

Registered No. G72013

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MR HARRY W. F. DRESSEL

2. DATE OF DEATH: 2-28-49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md
D. STREET ADDRESS (If rural, give location): 115 S. Symington Catonsville

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	M	5-7-1893	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PROPRIETOR	HARDWARE STORE	Md.	

13. FATHER'S NAME: Frederick Dressel

14. MOTHER'S MAIDEN NAME: ~~Hattie Eck~~ JENNY BECKMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: ~~MRS ETHEL DRESSEL~~ Mrs. Jennie Dressel (wife) ADDRESS: ~~Same~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: indefi.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-20 , 19 49 *to* 2-28 , 19 49 *that I last saw the deceased alive on* 2-28 19 49 *and that death occurred at* 1:35 *a.m. from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allyn R. Rudd M. D.	Liberty Hospital	2-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	March 3 1949	LOUDON PARK	BALTO, MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	Huntington Williams, M.D.	Harry H. Wyche	4101 EDMONDSON AVE.

VS 150

94a

PLEASE WRITE PLAINLY, with ink. Underline the correct age in especially important. Physician: please write the cause of death clearly and

2014 BALTIMORE CITY HEALTH DEPARTMENT 070.2 G 72014

BIRTH NO. B.C. 49-02256 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Andrew Lee Jr

2. DATE OF DEATH: 2/4/49

3. PLACE OF DEATH: a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 823 Madison ave

3. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: 37 hrs (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	N	Single	2/3/44		1	37

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): New Born Infant

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Joseph Andrew Lee

14. MOTHER'S MAIDEN NAME: Mary Lucile Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mary Lucile Lee ADDRESS: 823 Madison ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Syphilis (?)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/3 1944, to 2/4 1944, *that I last saw the deceased alive on* 2/4 1944, *and that death occurred at* 8:15 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles Waddell M. D.

23B. ADDRESS: J. C. Hopkins H

23C. DATE SIGNED: 2-8-44

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE:

24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School

24D. LOCATION (City, town, or county) (State):

FEB 24 1949

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

23. FUNERAL DIRECTOR: Commissioner of Health

ADDRESS:

VS 150

30F

PLEASE WRITE PLAINLY, with ink. Physician: please write the cause of death clearly and correct age is especially important.

72015 BALTIMORE CITY HEALTH DEPARTMENT 776 G72015

BIRTH NO. BC.49-0219 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): Baby Coleman

2. DATE OF DEATH: 2-1-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 2000 Rainer Ave

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 2-1-49
9. AGE (In years last birthday): If Under 1 Year: Months, Days; If Under 24 Hours: Hours 7, Min. 24

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Eddie Coleman
14. MOTHER'S MAIDEN NAME: Maggie L. Sweeney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother ADDRESS: 2000 Rainer Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Premature Labor
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from ____, 19__, to ____, 19__, that I last saw the deceased alive on ____, 19__ and that death occurred at ____ m., from the causes and on the date stated above.*

23A. SIGNATURE: Ralph W. Rechtman M. D.
23B. ADDRESS: 4 L b Baltimore Md
23C. DATE SIGNED: 2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: Feb 4 49.
24C. NAME OF CEMETERY OR CREMATORY: Retained by Lovitt Still
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: ADDRESS:

VS 150

PLEASE WRITE LEGIBLY. Items 1, 2, 3, 4, 5, 6, 8, 9, 11, 13, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25 must be completed. Please write the cause of death in item 18 even if the correct age is especially important. Physician: please write the cause of death in item 18 even if the correct age is especially important.

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G7205 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G7205 Registered No.

1. NAME OF DECEASED (Type or Print): BROTHER ARCADIUS, C.F.X. (Edward Liese)

2. DATE OF DEATH: 2/27/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt. St. Joseph's College 4403 Frederick avenue

c. Length of stay in Baltimore: Unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4403 Frederick avenue

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 8/29, 1859
9. AGE (In years last birthday): 89 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Xaverian Brother
10B. KIND OF BUSINESS OR INDUSTRY: Teacher
11. BIRTHPLACE (State or foreign country): Westphalia, Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Liese
14. MOTHER'S MAIDEN NAME: Josepha F. Leimel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Bro. Victorian C.F.X. ADDRESS: 4403 Frederick ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

(B) Arteriosclerosis

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1, 1948, *to* Feb 27, 1949, *that I last saw the deceased alive on* Feb 27, 1949, *and that death occurred at* 10 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert C. Walsh M.D.
23B. ADDRESS: 2151 Wilkens ave.
23C. DATE SIGNED: 2-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/2/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949
REGISTRAR'S SIGNATURE: Hampton Williams, M.D.
25. FUNERAL DIRECTOR: Chas. J. Evans & Son
ADDRESS: 118 N. Mt. Royal Ave 29

VS 150

PLEASE WRITE PLAINLY. Physician: please write the cause of death in terms of disease and not in terms of mode of dying, such as heart failure, asphyxia, anemia or uremia. Be sure that cause, or causes, stated will indicate the correct age is especially important.

G7207 ✓

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

583 Registered No. G7207

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Ditty

2. DATE OF DEATH: Feb. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 327 West 27th Street 17-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	Sept 12-1906	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffer	Self	Howard Co. Maryland	Yes

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Milton J. Ditty	Bessie Black

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, unless unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	Yes	220-01-6988	Union Memorial Hospital	

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, with ink. Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fatty degeneration of liver
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].

23A. SIGNATURE	23B CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
George L. Merrill M.D.		2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	3/2/49	St Peters Cemetery	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	[illegible]	Earl B Mottu	402-E-W-St

VS 151

124 B

G72018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450.0

G72018

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) HENRY REICH

2. DATE OF DEATH February 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2401 Kloman Street 75 33

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months Days	If under 24 hours: Hours Min.
male	white		Feb 1, 1869 (80)	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sexton	Church	Baltimore Md	

13. FATHER'S NAME John Reich

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT
No			John Reich 1238 Linden Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteir-sclerosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl M Bowyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED March 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/2	Loudon Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Thurlington Williams, M.D.	Nelson Corkran Inc	1218 Park Ave

VS 151

PLEASE WRITE PLAINLY, with ... correct age is especially important. Physicians: please write the cause of ... greater clearly and ...

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G7201 9

G7201 9

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thomas Marshall Button

2. DATE OF DEATH Feb. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3318 Elmley Ave

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3318 Elmley Ave.

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 22, 1856
9. AGE (In years last birthday) 92
If under 1 year: Months, Days. If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Button
14. MOTHER'S MAIDEN NAME Emogene Brochers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS Mrs Mary Button, 3318 Elmley Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage c left sided paralysis. — 5 days.
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Arteriosclerotic Cardio-vascular disease
DUE TO
(C) - Senility

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from Feb. 25, 1949 to Feb. 28, 1949 that I last saw the deceased alive on Feb. 28, 1949 and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE J. Stevens M. D.
23B. ADDRESS 3400 Erdman Ave
23C. DATE SIGNED 3/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 3/3/49
24C. NAME OF CEMETERY OR CREMATORY Parkwood
24D. LOCATION (City, town, or county) (State) Parkville, Md.
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR MAR 2 1949
REGISTRAR'S SIGNATURE Chas. Livingston Williams, M.D.
25. FUNERAL DIRECTOR William Cook, Inc., 1217 St. Paul St.

931

VS 150

PLEASE WRITE PLAINLY. Physician: please write the cause of death in the correct age is especially important.

G7/2020 27-15 G7/2020

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Frank Edward Lee
2. DATE OF DEATH: Feb. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2004 Kelly Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2004 Kelly Ave. 27-15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	Colored	Single	March 2, 1882	66	11	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Porter	—	Baltimore Co. Md.	U. S. A.

13. FATHER'S NAME: Joseph L. Lee
14. MOTHER'S MAIDEN NAME: Josephine Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		None	Mrs. Bessie L. Harris	2004 Kelly Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio Vascular. — INTERVAL BETWEEN ONSET AND DEATH: 15 years
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 15 1949 *to* Feb 27, 1949 *that I last saw the deceased alive on* Feb 27, 1949 *and that death occurred at* 8:45 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. H. White M. D.	515 Cathedral St	2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/2/1949	Mt. Calvary	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	(Mrs.) Lillian [illegible]	Geo. Lange A. Holland	1651 Druid Hill Ave

VS 150

PLEASE WRITE LEGIBLY. Print correct age is especially important. Physician please write the cause of death

93D

6720 21

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. | Registered No. 6720 21 Mann

1. NAME OF DECEASED (Type or Print): Mary L. Dorman
2. DATE OF DEATH: Feb. 27, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2436 Brentwood Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2436 Brentwood Ave. 1103

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Single	May 12, 1878	70	9	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Chestertown, Md.	U. S. A.

13. FATHER'S NAME: David Dorman
14. MOTHER'S MAIDEN NAME: Frances Madison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		None	Miss Susie Dorman	2436 Brentwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 1, 1949, to Feb 27, 1949, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 4:30 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	2329 Guilford Ave	Mch. 1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/2/1949	Mt. Zion	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Registrar for Williams, M.D.	Lange & Holland	163 Edmondson Ave

PLEASE WRITE PLAINLY. Physician: please write the cause of death correctly. Correct age is especially important.

VS 150

1210

G7/2022 G7/2022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4/3 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George Thomas Wilson

2. DATE OF DEATH Feb. 26 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 N. Franklin St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18 ward

c. Length of stay in Baltimore 51 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 90 N. Franklin St.

5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Aug. 5 1897 | 9. AGE (In years last birthday) 51 | If Under 1 Year: Months 6 Days 18 | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Wilson | 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mrs. Julia Arnold | ADDRESS 90 N. Franklin St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: one day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio-Vascular Disease — unknown

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Previous Cerebral Hemorrhage 5-6 yrs ago

19A. DATE OF OPERATION None | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 10, 1949, *to* Feb 26, 1949, *that I last saw the deceased alive on* Feb 26, 1949, *and that death occurred at* 12:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE George McDonald, M. D. | 23B. ADDRESS 844 N Carey | 23C. DATE SIGNED 2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/2/1949 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn | 24D. LOCATION (City, town, or county) (State) Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR MAR 2 1949 | REGISTRAR'S SIGNATURE Christopher Williams, M.D. | 25. FUNERAL DIRECTOR Geo. W. Holland | ADDRESS 1631 Druid Hill Ave

VS 150

PLEASE WRITE PLAINLY. Be sure to give correct age is especially important. Physician: please write the cause of death plainly.

937

G7202 3 ✓ 3.5 G7202 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-00135 Registered No.

1. NAME OF DECEASED (Type or Print): Brenda Delores Howard
2. DATE OF DEATH: 1-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. 25 Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1413 N. Bruce St. 15 or

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
female	Negro		1-5-49		25	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME: Leonard Joseph Howard
14. MOTHER'S MAIDEN NAME: Violet Catherine Cole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			mother	1413 N. Bruce St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO
(B) Pulmonary Congestion
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Prematurity

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert L. Bowles M. D.	Provident Hosp	2/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	2/24/49	Interred by Hospital	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Emma W. Williams, III		

VS 150

PLEASE WRITE PLAINLY. Physician: please write the cause of death clearly and correct age is especially important.

159

G720.34

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G720.34 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES BOARDLE

2. DATE OF DEATH February 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days 11 03

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 835 Linden Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored		?	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?	?	?	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO Atelectasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO Pyelonephritis

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George L. Merrill M.D.	☑	2/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	FEB 25 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Thurlington for Williams, M.D.	Commissioner of Health	

VS 151

1230

PLEASE WRITE PLAINLY, with ink. Cross out wrong answers and write correct answer. Be especially careful to see that cause of death clearly and logically stated. Physician: please write the cause of death clearly; important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

151 Registered No. 6720c5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madeira Ave
(c) Hospital or institution: Mt Wilby Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1176 Shields Pl. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cesare Bastas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Italy. Md. (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant E. Williams

(b) Address 1319 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School FEB 25 1949

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAR 2 1949 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1949 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1949 to 2-13 1949. and that I last saw him alive on 2-12-1949.

Immediate cause of death	Duration
Gastric Carcinoma	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Jayson M. D.

Address 600 Washington Ave Date signed 2/13/49

46 B

VS 150

GM. 125-30

G720,26

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 673

G720,26

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Pinkney Washington

2. DATE OF DEATH: 2-26-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital 4940 Eastern Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1310 E. Chase ST. 10 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 1 Hour: Hours	Min.
M	N	Sep.	Aug 17- 1901	47				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	

13. FATHER'S NAME: Harry Washington

14. MOTHER'S MAIDEN NAME: Lily Pinkney (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Records Balto. City Hospitals	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia	1 Month
DUE TO (B)	Arteriolar Nephrosclerosis	2 Yrs.
DUE TO (C)	Syphilitic Heart Disease	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-5-19[illegible], *to* 2-[illegible]-19[illegible], *that I last saw the deceased alive on* 2-26-1949, *and that death occurred at* 2:20 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. W. Cooper M. D.	4940 Eastern Ave.	2-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 2/49	Cheltenham Md.	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	Mrs Lott A. Elliott & Daughter	1129 N. Caroline St

VS 150

30E

PLEASE WRITE LEGIBLY. Physician please write the cause of death in plain terms. Omit abbreviations. Be sure correct age is especially important.

G7207 ✓ G7207

BALTIMORE CITY HEALTH DEPARTMENT 38 1 0 X

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES GROVER COTTON

2. DATE OF DEATH March 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S. Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: Yrs. 55 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE NJ
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) W. Collingswood
D STREET ADDRESS (If rural, give location) 521 Jessamine Ave.

5. SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
M	W	Married	5/3/87	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Lt. Commander USCG	USCC	NC	USA

13. FATHER'S NAME: James Cotton

14 MOTHER'S MAIDEN NAME: Alice Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
Yes		--	Records-	US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Laennec's Cirrhosis	Unknown
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 5, 1949, *to* Mar. 1, 1949, *that I last saw the deceased alive on* Mar. 1, 1949, *and that death occurred at* 8:40 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Stuart W. Sessoms M. D.	US Marine Hospital, Balto, Md.	3/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Removal	3/4/49	Collingswood	Collingswood NJ.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	Lilly & Zeiber	402 E. Lafayette St

VS 150

124a

PLEASE WRITE PLAINLY, with ink or indelible pencil. Be sure to fill in all items. Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and

6720-28

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6720-28

BIRTH NO. 334 Registered No.

1. NAME OF DECEASED (Type or Print): EUGENIA R WHYTE
2. DATE OF DEATH: MAR 1 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Washington apts Charles St & Mt Vernon Pl.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Washington apts Charles St & Mt Vernon Pl.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	widowed	mar 3 1857	91	11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Balto	

13. FATHER'S NAME: Decatur H Miller
14. MOTHER'S MAIDEN NAME: Eliza Hare

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Louisa H. Boston	Washington apts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteriosclerosis -	10 yrs
DUE TO	general and cerebral	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Bronchopneumonia	3 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 18, 1948 *to* Mar 1, 1949 *that I last saw the deceased alive on* Dec. 28, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Holmes Boyd M. D.	24 E. Eager st	Mar 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 3 1949	Green Mount	Balto, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	[illegible] Williams, M.D.	Henry W Jenkins Sons	1401 York Rd

VS 150

107

PLEASE WRITE PLAINLY. Physician: please write the cause of death in terms of disease and the correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 3720 (3720)

BIRTH NO. 3720

1. NAME OF DECEASED (Type or Print): LEWIS MILLENSON

2. DATE OF DEATH: 3-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levendale

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write R.F.D. and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4108 Garrison Boulevard

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 85 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Samuel Dobres ADDRESS: 4108 Garrison Boulevard

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Cerebral thrombosis — 4 days

DUE TO

(C) Cerebr. arteriosclerosis — years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-16 1947 to 3-2 1949 that I last saw the deceased alive on 3-2, 1949, and that death occurred at 5 EE a m., from the causes and on the date stated above.

23A. SIGNATURE: Henry Nagel M.D.
23B. ADDRESS: Levindale
23C. DATE SIGNED: 3-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-2-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

8212

PLEASE WRITE PLAINLY. Physician please write the cause of death in the manner which is especially important. Be sure that the entries are complete and correct.

72050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1 G72050

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Anna Elizabeth Hesser

2. DATE OF DEATH: March 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 415 E. Chase St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 415 E. Chase St. 10 01

c. Length of stay in Baltimore: 15 yrs (Yrs. Mos. Days)

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 11, 1864
9. AGE (In years last birthday): 85 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stadium Mfg. Co
10B. KIND OF BUSINESS OR INDUSTRY: Sewing Factory
11. BIRTHPLACE (State or foreign country): Frederick Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Stauffer
14. MOTHER'S MAIDEN NAME: Ella Freburger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO. 219-07-5639
17. INFORMANT: James R. Agle ADDRESS: 415 E. Chase St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 2, 1949 *to* March 1, 1949, *that I last saw the deceased alive on* March 1, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jack J. Singer M.D. M. D.
23B. ADDRESS
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 4, 49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR: MAR 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. F. Elmer & Sons ADDRESS: Reisterstown, Md.

VS 150

94a

PLEASE WRITE PLAINLY. Cause of death is important. Physician: please write the cause of death in terms of disease and correct age is especially important.

G720.51 ✓ X G720.51

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 180

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Caroline Rehrback
2. DATE OF DEATH: 3/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 16 E First Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months Days	If under 24 Hours: Hours Min.
F	W	Married	June 16, 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H.W.	None	Germany	USA

13. FATHER'S NAME: Daniel Besonz
14. MOTHER'S MAIDEN NAME: Ida Neugebauer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Husband	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Epidermoid carcinoma of Kidney with metastasis — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs?
DUE TO
(B) Pyonephrosis
DUE TO Renal Calculus
Pyelonephritis
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/26/49	Renal Calculus, Pyonephrosis	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/17, 19 9, *to* 3/1, 19 9, *that I last saw the deceased alive on* 3/1, 1949, *and that death occurred at* 9:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert R Jones Jr. M.D.	Maryland General Hospital	3/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-5-49	Cedar Hill	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	Hewitt Wilhelm	4401 Edmondson Ave

VS 150

PLEASE WRITE PLAINLY. Physician: please write the entries correctly. Cause of death is especially important.

52a

7720.52 G720.52

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HENRY G JACOB

2. DATE OF DEATH: FEB 28 '49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 509 S. BENTALOU ST

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D STREET ADDRESS (If rural, give location): 509 S BENTALOU ST 20-05

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: FEB 7, 1883
9. AGE (In years last birthday): 66
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED - BOOKBINDER
10B. KIND OF BUSINESS OR INDUSTRY: MORGAN MFG CO.

11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: HENRY JACOB

14. MOTHER'S MAIDEN NAME: ELIZABETH YINGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: MRS HENRY G JACOB - ADDRESS: 509 S BENTALOU ST

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Thrombosis	10 Minutes
ANTECEDENT CAUSES	DUE TO (B) Hypertension, Arterial Disease	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Arteriosclerosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

20. AUTOPSY? YES ☐ NO ☒

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 18, 1948, to Feb 26, 1949 *that I last saw the deceased alive on* Feb 26, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Alfred Cole M. D.
23B. ADDRESS: 1934 Druid Park Drive
23C. DATE SIGNED: Feb 28 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: MARCH 2 '49
24C. NAME OF CEMETERY OR CREMATORY: WESTCAN
24D. LOCATION (City, town, or county) (State): BALTO. MD

25. FUNERAL DIRECTOR: Harry A Wiehe - ADDRESS: 4101 EDMONDSON AVE

DATE RECEIVED BY LOCAL REGISTRAR: MAR 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

93D

VS 150

Please write this cause of death in plain words. Physician: please write the cause of death in plain words. Be specific and important. Omit terms like "Chronic" or "Old age" unless correct age is especially important.

BIRTH NO. 7720-33

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67720-33

1. NAME OF DECEASED (Type or Print): MYRTLE P. WALTZ

2. DATE OF DEATH: 2/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3816 Grantley Rd.
C. Length of stay in Baltimore: 67 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3816 Grantley Rd. 15 11

5. SEX: f
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: March 19,1869
9. AGE (In years last birthday): 79 yrs. (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): f.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Richmond, Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry T. Anderson
14. MOTHER'S MAIDEN NAME: Mary Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): --
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: --

17. INFORMANT: Miss Ethel F. Waltz — ADDRESS: 3816 Grantley Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: John R. Davis, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/2/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 2 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 151

937

PLEASE WRITE PLAINLY. Important: please write the cause of death exactly, correct age is especially important. Physician

G7203.4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1 G7203.4

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KATIE FRANK

2. DATE OF DEATH: March 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4404 Fernhill Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 4404 Fernhill Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
female	white	widow	July 9, 1868	80 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	

13. FATHER'S NAME: John Mueller

14. MOTHER'S MAIDEN NAME: Catherine Weber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	none	Mrs. Gordon H. McKewin	4404 Fernhill Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Occlusion	2 yrs
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Generalized Arteriosclerosis	10 yrs
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1949 *to* March, 1949 *that I last saw the deceased alive on* 3-1, 1949, *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dalton T Elliott M. D.	4509 Liberty Heights Ave	3-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/4/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

94a

PLEASE WRITE PLAINLY — please write the entries correct age is especially important. Physician

G7/20.5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 198

BIRTH NO.

Registered No.

G7/20.5

1. NAME OF DECEASED (Type or Print): GEORGE VAUPEL

2. DATE OF DEATH: March 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2000 McKean Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2000 McKean Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
male	white	married	Sept. 19, 1873	75 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-		Baltimore, Md.	

13. FATHER'S NAME: John G. Vaupel

14. MOTHER'S MAIDEN NAME: - Sheboik

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		no	Mr. John G. Vaupel	2000 McKean Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral Lymphoblastoma (neck) — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
March 1948	Biopsy of gland of neck.	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Jan 1948 to March 1949 that I last saw the deceased alive on Feb 20 1949 and that death occurred at 10A. m., from the causes and on the date stated above.

23A. SIGNATURE, M. D.	23B. ADDRESS	23C. DATE SIGNED
Robert T. Levy	1844 W. North Ave	March 2-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/4/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE*	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

55E

PLEASE WRITE PLAINLY. Be sure that all items are correct and complete. Physician: please write the cause of death in terms of disease, and not in terms of mode of dying, such as heart failure, asphyxia, anemia, or uremia. Items 19 and 20 are especially important. Physician: please write the cause of death in terms of disease, and not in terms of mode of dying, such as heart failure, asphyxia, anemia, or uremia.

G720.36 ✓ 1 G720.36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY HACHEMEISTER

2. DATE OF DEATH: Feb. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1106 W. Baltimore St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1106 W. Baltimore St.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: March 8, 1865
9. AGE (In years last birthday) If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.: 83 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Julius Holle
14. MOTHER'S MAIDEN NAME: Anna Dressel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): -
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: no
17. INFORMANT: Mrs. Lillian E. Naff
ADDRESS: 1128 W. Balto. St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) coronary sclerosis — unknown

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 28, 1949 *to* Feb 28, 1949 *that I last saw the deceased alive on* Feb 28, 1949, *and that death occurred at* 9 00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Nathan Racusin M. D.
23B ADDRESS: 206 S. Gilmor St.
23C DATE SIGNED: 3-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/4/49
24C NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

94a

PLEASE WRITE PLAINLY. Physician: please write the entries on this certificate carefully. Be sure that the correct age is especially important.

6720.37

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 6720.37

1. NAME OF DECEASED (Type or Print): Lelia Roberts Johnson

2. DATE OF DEATH: Feb. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1708 Mosher Street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1708 Mosher Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	Feb. 28, 1891	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U. S. A.

13. FATHER'S NAME: Henry Campbell

14. MOTHER'S MAIDEN NAME: Adlina Henson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Edward C. Johnson	1708 Mosher St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) arteriosclerosis — ?

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-25-, 1949 *to* 2-28-, 1949 *that I last saw the deceased alive on* 2-27-, 1949, *and that death occurred at* 4:50 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John E. J. Compere, M. D.	639 N. Carey St	3-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-3-49	Mt. Calvery Cem	Anne Arundel Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	Mrs. Frances A. Hemsley	578 W. Biddle St.

VS 150

83a

PLEASE WRITE PLAINLY — correct age is especially important. Physician: please write the cause of death

7720.38

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G7720.38

1. NAME OF DECEASED (Type or Print): Channie Thompson

2. DATE OF DEATH: 9-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1043 N. Carlisle St

c. Length of stay in Baltimore: 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1043 N. Carlisle St 7-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	March 13, 1856	92		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None			

13. FATHER'S NAME: Isaac Benjamin

14. MOTHER'S MAIDEN NAME: Rosanna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Isadora Jordan Livingston ADDRESS: 1043 N. Carlisle

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Generalized Arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 28 Jan. 1949, *to* 25 Feb. 1949, *that I last saw the deceased alive on* 20 Feb. 1949, *and that death occurred at* 7 40 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Stanford R. Linsenmeyer, M. D.	2209 Druid Hill Ave	3-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 2/49	Mt. Calvary Cem.	A A County Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	Mr. Robt. A. Elliott, Draytby	1129 N. Carlisle

VS 150

94a

G720.39
Dr. Peake

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G720.39
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): AMELIA E. GONDER

2. DATE OF DEATH: MAR. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3313 Lerch Drive
c. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3313 Lerch Drive 27-43

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year Months, Days	If under 24 hours Hours, Min.
female	white	widowed	June 22, 1860	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Md.	

13. FATHER'S NAME: Charles F. Hessler

14. MOTHER'S MAIDEN NAME: Sophia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Mrs. Lillie Bull, 3313 Lerch Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchopneumonia	2 days
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1944 *to* 3-1-, 1949 *that I last saw the deceased alive on* 2-26-, 1949 *and that death occurred at* 4:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. W. Peake M. D.	4508 Harford Road	3-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-3-49	Parkwood	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 2 1949	Thurlington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

107

PLEASE WRITE CLEARLY — Important: Physician: please write the cause of death correct age is especially important.

CERTIFICATE CORRECTED 3-9-49

Dr. Breman

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

416 Registered No. 67205

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CATHERINE C. JOYCE

2. DATE OF DEATH: Mar. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2901 Shirey Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2901 Shirey Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	June ~~21, 1893~~ 20, 1893	56 (55)		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Peter Noha

14 MOTHER'S MAIDEN NAME: Anna Bourek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. Catherine Funk, ADDRESS: 2901 Shirey Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart Disease — DUE TO

ANTECEDENT CAUSES

(B) Rheumatic Fever — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

1. Diabetes 2. Pernicious Anemia

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1946 *to* March, 1949, *that I last saw the deceased alive on* ~~March~~ Feb 28, 1949, *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas J. Brennan M. D.

23B. ADDRESS: 5217 Harford Road

23C. DATE SIGNED: Mar 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Buairl

24B. DATE: 3-5-49

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral

24D LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 2 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road.

VS 150

61

Please write the entries in this certificate in ink. Physician: please correct age is especially important.

67204-1 143 67204-1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. BANISTER

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles A. Bannister — OR — 2. DATE OF DEATH: 2/28/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 6
d. STREET ADDRESS (If rural, give location): 3714 Southern Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	Married	9/1/1888	60		

10a. USUAL OCCUPATION (Give kind of work, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor	Construction	Md.	U. S. A

13. FATHER'S NAME: Grafton Bannister
14. MOTHER'S MAIDEN NAME: Bertie Burkens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown		Wife - Mildred	3714 Southern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — Interval between onset and death: 5-6 hrs.

DUE TO

(B) Hypertensive Cardiovascular disease — Interval between onset and death: ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 2/28 1949 to 2/28, 1949, that I last saw the deceased alive on 2/28 1949, and that death occurred at 8.45 P. m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Herbert J. Levickas M. D.	St. Agnes Hospital	2/28/49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	3/4/49	Parkwood	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	Leonard J. Ruck	5305 Harford

VS 150

PLEASE WRITE CLEARLY — correct age is especially important. Physician: please write the cause of death in plain terms.

G720-42

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. G720-42 Registered No.

1. NAME OF DECEASED (Type or Print): Thomas W. Clark
2. DATE OF DEATH: 2/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2627 Hampden Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 2627 Hampden Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	Married	Sept. 1, 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Brakeman	Railroad	Baltimore, Md.	

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		705-10-8811	Mrs Alice Clark	2627 Hampden Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
John R. Davis M.D	☒	2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/3/49	Druid Ridge	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	William Cook, Inc.,	1217 St.

VS 151

PLEASE WRITE IN INK. Information must be complete and correct as far as possible. Physician: please write the causes of death clearly and correct age is especially important.

931

G7203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G7203

1. NAME OF DECEASED (Type or Print): Catherine M. Keelan

2. DATE OF DEATH: 2/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3712 Gelston Drive

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3712 Gelston Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hrs. / Min.
Female	W.	Widow	May 28/66	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H.W.	None	Balto.Md.	

13. FATHER'S NAME: Michael Leonard

14. MOTHER'S MAIDEN NAME: Dignan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			3712 GelstonDrive.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 31 days

DUE TO

(B) General Arteriosclerosis ✓

DUE TO

(C) none

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	✓	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	✓	✓

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
✓ m.	WHILE AT WORK ☐ ✓ NOT WHILE AT WORK ☐	✓

22. *I hereby certify that I attended the deceased from* Jan 28, 1949 *to* Feb 28, 1949 *that I last saw the deceased alive on* Feb 27, 1949, *and that death occurred at* 7A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Talbot Howard M. D.	1219 Cathedral Street	Mar 1-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/3/49	New Cathedral, 4300 Old	Frederick Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	Harry A. Winterling	2201 Edmondson Ave.

VS 150

83a

G7204 — G7204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. — Registered No. 490

1. NAME OF DECEASED (Type or Print): Evelyn Hamilton

2. DATE OF DEATH: Feb 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 917 N. Fulton Avenue

c. Length of stay in Baltimore: 15 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 917 N. Fulton Avenue 16-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Married	Oct 21, 1921	27 28 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Battleboro, N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Roscoe Whitehead

14. MOTHER'S MAIDEN NAME: Ermer Cozart Edwards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ermer C. Edwards ADDRESS: 920 N. Appleton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Lobar pneumonia	3 days
DUE TO		
(B)	Acute Cardiac failure	1 day
DUE TO		
(C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 2/23/49 *to* 2/26/49, *that I last saw the deceased alive on* 2/26/49, *and that death occurred at* 1:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: H. L. Jackson M. D.

23B. ADDRESS: 600 N Arlington Ave

23C. DATE SIGNED: 2/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3/3/49

24C. NAME OF CEMETERY OR CREMATORY:

24D. LOCATION (City, town, or county) (State): Rocky Mount - N.C.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 2 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Chas. R. Law ADDRESS: 802 Madison Ave--1

VS 150

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Please write correct age in especially important. Physician: please write the causes of death clearly.

#20:5

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-04103 — 76 — Registered No. G#20:5

1. NAME OF DECEASED (Type or Print): Downey, Baby Helen
2. DATE OF DEATH: 3/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSP.
C. Length of stay in Baltimore: 5 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 311 Font Hill Ave
FRANKLIN SQUARE HOSP

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	SINGLE	2/25/49		5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	MARYLAND (Balto.)	U.S.A.

13. FATHER'S NAME: HOWARD DOWNEY
14. MOTHER'S MAIDEN NAME: ADA TOWNSEND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		no	FATHER	311 FONT HILL AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Prematurity
(B) DUE TO: Cause Unknown

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/25, 1949 *to* 3/2, 1949, *that I last saw the deceased alive on* 3/1, 1949, *and that death occurred at* 4:45 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Michael P. Ramunda, M.D.
23B. ADDRESS: Franklin Sq. Hospital
23C. DATE SIGNED: 3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/2/49	Meadowridge Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Hunter for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

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Please write clearly with ink. Items 1 to 17 must be completed. Physician: please write the cause of death in terms of disease, and indicate the correct age if especially important.

G7206 G7206

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 4272

1. NAME OF DECEASED (Type or Print): George Chester

2. DATE OF DEATH: 2/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md. General Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 716½ N. Franklin St. 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Separated	12-9-1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Chester
14. MOTHER'S MAIDEN NAME: Emma Nelson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Ethel Summers ADDRESS: 724 Pierce ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* _____ *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from; natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-3-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 2 1949
REGISTRAR'S SIGNATURE: Remington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R Williams
ADDRESS: 934 Lanvale St.

VS 151

PLEASE WRITE IN INK. Physician: please write the causes of death clearly and give correct age in especially important.

G7207 ✓ G7207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.H 38573 490 Registered No.

1. NAME OF DECEASED (Type or Print) Eugene Mulock

2. DATE OF DEATH February 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 1208 S Front Court

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Child	12-23-45	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Lessy

14. MOTHER'S MAIDEN NAME Eldora Mulock.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia & dehydration
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C) Post meningitis Spastic with severe physical & mental retardation

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: over

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-24 1949 *to* 2-24, 1949 *that I last saw the deceased alive on* 2-24, 1949, *and that death occurred at* 4:40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Lowell Huntley M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 3-2-49

24C. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem

24D. LOCATION (City, town, or county) (State) Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 2 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Mrs Katie R. Williams ADDRESS 3221 Edmondson Ave

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correct age is especially important. Physician: please write the

G7208 ✓ E-987-0 G7208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 153-1

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WALTER DENNIS N-853

2. DATE OF DEATH: February 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1312 North Central Avenue 9-09

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	colored	married	April 5, 1908	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Louise Dennis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hester B. Dennis ADDRESS: 1312 N. Central Avenue

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Stab wound of brain	
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): sideyard

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1312 North Central Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 2 27 49 4. P. M.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? sharp instrument

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Feb. 28, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 3-4-49

24C. NAME OF CEMETERY OR CREMATORY:

24D. LOCATION (City, town, or county) (State): Chester, S. C.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 2 1949

REGISTRAR'S SIGNATURE: [signature] Registrar of Vital Statistics

25. FUNERAL DIRECTOR: Joseph B. Lock, Jr. ADDRESS: 1304 N. Central Ave

VS 151

167

Please write in ink and print. Physician's correct age is especially important. Please write the cause of death

G7204 9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G7204 9

1. NAME OF DECEASED (Type or Print): Edward Williams

2. DATE OF DEATH: 2-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Provi Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provi Hospitle

c. Length of stay in Baltimore: Yrs. 17 Mos. 0 Days 3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE
COUNTY
1331 Upton St
c CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto City
D STREET ADDRESS (If rural, give location): 1331 Upton St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	Colord		unknown	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		unknown	U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Maggie Thomas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 40 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive C-V. arteriosclerotic disease

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Generalized Arteriosclerosis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-21 19 49 *to* 2-23- 19 49, *that I last saw the deceased alive on* 2-23- 19 49. *and that death occurred at* 9:30 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. E. Brady Jr. M. D.	Provident Hospital	2-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/3/49	Mt Calvery	A. A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR ADDRESS
MAR 2 1949	Huntington Williams M.D.	William A Jackson 916 Penna Ave

VS 4-50

931

"Please write the name correct age is especia important. Physicia ; please write the name

BIRTH NO. G72050

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72050

1. NAME OF DECEASED (Type or Print): ANTHONY T. BANNER

2. DATE OF DEATH: February 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: 25 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 647 West Lombard Street

4-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	single	Feby 27. 1878	~~55~~ 71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Church Janitor		New York	U.S.

13. FATHER'S NAME: Jacob Banner

14. MOTHER'S MAIDEN NAME: Florentin Khostein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT ADDRESS
		Rev. L.F.Ransom

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary occlusion	
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE M.D.	23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
[signature]		March 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	Mch. 2. 1949	Loudon Park Cemetery	3801 Frederick Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR ADDRESS
MAR 2 1949	[signature] M.D.	John O. Mitchell & Sonsinc. 1900 Eutaw pla

John O. Mitchell

VS 151

94a

G72051 ✓ G72051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

413 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Maria L. Day

2. DATE OF DEATH: March 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 8 W. Read St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

C. Length of stay in Baltimore: 53 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Maryland; B. COUNTY none; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore; D. STREET ADDRESS (If rural, give location) 8 W. Read Street

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: October 19, 1870

9. AGE (In years last birthday): 78 79 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ? Lansky

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Dr. Lester W. Day ADDRESS: 8 W. Read St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic hypertensive cardio vascular disease — years

DUE TO

(C) —

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes mellitus — years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* September, 1948, *to* March 1, 1949, *that I last saw the deceased alive on* 1 March, 1949, *and that death occurred at* 9:10 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. Douglas Lokard M. D.

23B. ADDRESS: 802 Cathedral St.

23C. DATE SIGNED: 2 March, 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3 - 3 - 49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: MAR 2 1949 VS 150

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Pl

M B Mitchell

For Registrar - Doctors

61

Correct age is especially important. Physician: please write out

G72052

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72052 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Beulah Thompson House

2. DATE OF DEATH: March 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3512 Clifton Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3512 Clifton Ave. 1 5 48

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	widowed	October 30, 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore	U. S.

13. FATHER'S NAME: Thomas E. Thompson

14. MOTHER'S MAIDEN NAME: Mary White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Mary H. Wiehe	2564 S. Rookwood Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of ovary
DUE TO metastasis
(B) none
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
none

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
May 6/1948	Cancer of ovary, adherent to mesosigmoid & parietal peritoneum	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 2, 1930, *to* March 2, 1949, *that I last saw the deceased alive on* March 2, 1949, *and that death occurred at* 10⁴⁰ A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jno A. Ludscher M. D.	12 E. Eager St. Balto Md	March 2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/4/49	Druid Ridge	Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Lemuel Williams, M.D.	John O. Mitchell & Sons, Inc.	1900 Eutaw Pl.

Morton B. Mitchell

VS 190

Dr. John Ludscher

49a

correct age is especia important. Physici

G720:53 BALTIMORE CITY HEALTH DEPARTMENT G720:53

CERTIFICATE OF DEATH

BIRTH NO. 163 Registered No.

1. NAME OF DECEASED (Type or Print): Augustus C. Binswanger

2. DATE OF DEATH: 3/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: 73 Yrs. ___ Mos. ___ Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Altamont Hotel 11-34

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: 4/19/1875
9. AGE (In years last birthday): 73 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Simon Binswanger
14. MOTHER'S MAIDEN NAME: Sarah Pina
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ?
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. August R. Schiff 5607

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchogenic Carcinoma
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/18, 1949 *to* 3/1, 1949 *that I last saw the deceased alive on* 3/1, 1949 *and that death occurred at* 7:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marjorie Brown M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 3/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 3/3/49
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: David Sondheim ADDRESS: 1908 Eutaw Place

VS 150

47c

G720.54 ✓ G720.54

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

162 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN CARROLL HOOK

2. DATE OF DEATH: Feb. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore: Yrs. 44 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5008 Liberty Heights Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	? 1879	? 69	8	19

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Md.	USA

13. FATHER'S NAME: William Hook

14. MOTHER'S MAIDEN NAME: Susan Hatton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	SAW	219-22-2819	Records- US Marine Hospital, Balto. Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, left lung with metastases to brain — INTERVAL BETWEEN ONSET AND DEATH: unk.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 14, 19 49 *to* Feb. 27, 19 49 *that I last saw the deceased alive on* Feb. 27, 19 49, *and that death occurred at* 11:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Francis T. Dunn M. D.	US Marine Hospital, Balto. Md.	2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 2 1949	Lorraine Cemetery	Woodlawn Balto Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	Wells Amoreau	4516 Liberty Hts Ave

VS 450

479

correct age is especially important. Physician: please write the cause

G720.5 Flook ✓ G720.5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1.1

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lena Flook

2. DATE OF DEATH: 3/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write R.F.D. and give township): Baltimore 20-06
D. STREET ADDRESS (If rural, give location): 509 S. Caton Ave #29

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	5-2	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md.	

13. FATHER'S NAME: Fred Ames

14. MOTHER'S MAIDEN NAME: Alma

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	—	Wilbur H. Flook	509 S. Caton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure

DUE TO Arteriosclerotic cardiovascular disease & aortic stenosis + aurecillar flutter — 6 years +

(B) Pulmonary infarct - left — 5 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-28, 1949 *to* 3-1, 1949 *that I last saw the deceased alive on* 3-1, 1949, *and that death occurred at* 4 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Aubrey Johnson Venable, Jr. M.D.	St. Agnes Hospital	3-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 4-49	Loudon Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	F. B. Wisbert Funeral Home	1500 Eutaw Pl.

VS 150

92a

7

Please write the name correct age is especially important. Physician, please

G720:56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 420.1

G720:56

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Katherine L. Minton

2. DATE OF DEATH: 2/28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 726 E. 20th St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 726 E 20th St
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
Female	White	Single	1888	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Balto. Md.	

13. FATHER'S NAME: Patrick J. Minton

14. MOTHER'S MAIDEN NAME: Margaret M. Fahey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Leo McMahon ADDRESS: 726 E. 20th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

DUE TO

(B) Coronary Artery Disease — 6 mos

DUE TO

(C) Myocarditis — 1 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
3/3/49		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1, 1949 *to* Feb. 28, 1949, *that I last saw the deceased alive on* Feb 28, 1949 *and that death occurred at* 9.00 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas J. Waite, M. D.	3809 Greenmount Ave	3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/3/49	New Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 2 1949	Huntington Williams, M.D.	E.I.Fanning & Son	1938 E.Lafayette Ave.

VS-150

8

93E

correct age is especially important. Physician: please write the

G7205?

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 300.3

G720.?

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Anna Koppel
2. DATE OF DEATH: Mar 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2220 Braddish Ave 15-47

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	married	Oct, 16. 1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Abraham Mazaroff
14. MOTHER'S MAIDEN NAME: Matilda Yosolowitz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or details of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Maurice Koppel ADDRESS: 2220 Braddish Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary edema ; possible pulmonary embolism
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C) Schizophrenia, paranoid

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: appx. 36 hrs.

19A. DATE OF OPERATION: Jan. 7, 1949
19B. MAJOR FINDINGS OF OPERATION: Pre-frontal lobotomy, bilateral
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 7, 1949 *to* Mar 2, 1949, *that I last saw the deceased alive on* Mar 2, 1949, *and that death occurred at* 3 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: John C. Ozgewski M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: Mar. 2 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 3, 1949
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herrin Run Cem
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 3 - 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS: 1126 W North Ave

VS 150

84C

G#2058 G#7203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen Gore Larsen

2. DATE OF DEATH: Feb. 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland; B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4715 Liberty Heights Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore — Yrs. Mos. Days:

D. STREET ADDRESS (If rural, give location): 4715 Liberty Heights Avenue 28-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	married	April 4, 1912	36	10	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Louis J. Gore	Minerva Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
no	216-07-0101	Mr. Murrill Larsen, 4715 Liberty Heights

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 5 days

DUE TO

ANTECEDENT CAUSES

(B) Hypertension Cardio Vasc Disease 8 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1940 *to* March, 1949 *that I last saw the deceased alive on* Feb 24, 1949, *and that death occurred at* 8:35 *pm., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr Thos K Abbott M. D.	4509 Liberty Heights Ave	3-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	3/3/49	Woodlawn Cemetery	Woodlawn, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
MAR 3 - 1949	[illegible]	Wm. Cook, Inc., 1217 St. Paul Street

VS 150

93D

correct age is especia... important. Payable...

GM. 127185

72039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72039

BIRTH NO. 7221 Registered No.

1. NAME OF DECEASED (Type or Print): Edith Browne

2. DATE OF DEATH: 3- 2- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 astern Ave.
C. Length of stay in Baltimore: 4½ Months (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 519 N. Eutaw ST. 11-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	White	W	Dec. 24 1883	65	2	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	At Home	NJ.	

13. FATHER'S NAME: Charles Henry Paul

14. MOTHER'S MAIDEN NAME: Mary McKee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Records Balto. City Hospitals	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Broncho Pneumonia	7 Days
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Rheumatoid Arthritis	15 yrs
DUE TO		
(C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 2- 28- , 19 49 *to* 3- 2- , 1949, *that I last saw the deceased alive on* 3- 2- , 19 49, *and that death occurred at* 10.40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	B.C.H. 4940 Eastern Ave.	3-2 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/5/49	St. Peters	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 3 1949	[signature]	Wm Cook Inc.	27 St. Paul St.

VS 150

6

107

correct age is especia... important. Physici... please ...

72060

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

002 Registered No. G72060

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GUSTAV KEMP

2. DATE OF DEATH March 1,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1636 Montpelier Street
c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1633 Montpelier Street 9-7

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov.20, 1888
9. AGE (In years last birthday) 60 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker
10B. KIND OF BUSINESS OR INDUSTRY American Stores
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Gustav Kemp
14. MOTHER'S MAIDEN NAME Bonnie Winkle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-07-9407
17. INFORMANT Mrs. Mary G. Kemp- 1636 Montpelier ADDRESS ~~Str~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary tuberculosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH —

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 7 1948, to March 1, 1949 that I last saw the deceased alive on 3/1, 1949, and that death occurred at 7:50 a. m., from the causes and on the date stated above.

23A. SIGNATURE L. C. Schubert M. D.
23B. ADDRESS 4474 Kenwood Ave.
23C. DATE SIGNED 3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 3/4/49
24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial
24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.

DATE RECEIVED BY LOCAL REGISTRAR MAR 3 1949
REGISTRAR'S SIGNATURE Inspector of Statistics, M

VS 150

BALTIMORE - 13, MARYLAND 13B

G720.1 B.C.H.-10083 ✓ G720.1

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

57° Registered No.

1. NAME OF DECEASED (Type or Print): Frances Rakestraw

2. DATE OF DEATH: 3/1 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 408 N. Washington St. 6-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
F	W	Single	Sept. 30, 1944	4	5	0		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Md.	

13. FATHER'S NAME: Elmer L. Rakestraw

14. MOTHER'S MAIDEN NAME: Deone L. Turnbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Wm. Turnbaugh	408 N. Washington St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Bronchosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Lobar Pneumonia, R. Upper — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
H. J. McClafferty M.D.	☒ / ☐ / ☐	3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 4, 1949	Greenmount	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 3-1949	Registrar Baltimore, Md.	Ulrich Funeral Home	2008 Orleans St.

VS 151

1330

correct age is especia important. Physicia please write the cause

G720-52

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G720-52

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FREDERICK JOSEPH PARADIS

2. DATE OF DEATH: Mar. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: 23 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Millersville R.F.D.
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	Married	6/24/11	37		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Hardware	Haverhill Mass.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Albert J. Paradis	Bridget Mc Donald ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 2	032-10-1983	Records-	US Marine Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) 1- Bronchogenic carcinoma, right, ~~Lymphoma, mediastinal~~ DUE TO- primary bronchus.	Unknown
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) ~~2- Bronchopneumonia, right lung.~~ DUE TO	Unknown over
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Bronchopneumonia, right lung	Unk.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Feb. 7, 1949 *to* Mar. 2, 1949 *that I last saw the deceased alive on* Mar. 2, 1949 *and that death occurred at* 10 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nat. Van Ackeran M. D.	US Marine Hospital, Balto, Md.	3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	3/3/49		Haverhill, Mass.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 3- 1949	Registrar for Baltimore, Md.	George A. Farley	Cottman & Smyth Sts.

VS 150

47c

correct age is especially important. Physician, please write the

G72063

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

Registered No. G72063

1. NAME OF DECEASED (Type or Print): Harvey Lumpkin Godard

2. DATE OF DEATH: March 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U. S. Marine Hospital

C. Length of stay in Baltimore: 7 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY: Philadelphia
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Philadelphia
D. STREET ADDRESS (If rural, give location): 5783 Nassau Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	Sept. 27, 1904	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none-retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Godard

14. MOTHER'S MAIDEN NAME: Willie Logan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO: unknown

17. INFORMANT: Records, US.Marine Hospital, Balto, Md. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral hemorrhage
DUE TO frontal lobe, right

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: unk

19A. DATE OF OPERATION: 2/25/49

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February 23, 1949 *to* March 2, 1949 *that I last saw the deceased alive on* March 2, 1949 *and that death occurred at* 10:50 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: W Burton Haley M.D.

23B. ADDRESS: U. S. Marine Hospital, Balto, Md.

23C. DATE SIGNED: 3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: March 7-1949

24C. NAME OF CEMETERY OR CREMATORY: Midway Methodist Cemetery

24D. LOCATION (City, town or county) (State): SPALDING County, GRIFFIN Georgia

DATE RECEIVED BY LOCAL REGISTRAR: MAR 3 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Pott C & B.M. Walton ADDRESS: Pratt Street

VS 150

83a

correct age is especially important. Physician: please write the

7204 ✓ E 9815 G7204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Cornelius Wilson N 861.4

2. DATE OF DEATH 12:22 a.m. Feb. 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hosp.

c. Length of stay in Baltimore: Yrs. All Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Essex,
D. STREET ADDRESS (If rural, give location) Bengies, Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Single	4/27	22				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Middle River Md.	U.S.A.

13. FATHER'S NAME: Levi Wilson

14. MOTHER'S MAIDEN NAME: Lillian Petersson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: Levi Wilson Jr. Bengies Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet wound of aorta

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	public	Eastern Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
12 a.m. 2-27-49 m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X] undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
M.D.		2-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/3/1949	Chase Cem.	Chase Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 3 - 1949	Huntington Williams, M.D.	Elroy O. Wilson	1000 Pratt Ave.

VS 151

166

G72065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72065

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Amanda C. Harris

2. DATE OF DEATH: March 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3526 Poole Street

c. Length of stay in Baltimore: 70 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3526 Poole Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	September 22, 1856	92		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Carroll Co., Maryland	

13. FATHER'S NAME: Thomas B. Brothers

14. MOTHER'S MAIDEN NAME: Margaret Poole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	---	Lewis G. Harris	3526 Poole Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C.V. Dis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1949 *to* Mar 1, 1949 *that I last saw the deceased alive on* Feb 28 1949 *and that death occurred at* 1:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward L. Glassman M. D.	4031 Falls Rd.	3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 4, 1949	Mt. Pleasant	Carroll Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 3 - 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

correct age is especially important. Physician: please write the exact

93D

G72066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72066

BIRTH NO. 72066

1. NAME OF DECEASED (Type or Print): Archibald D. Freeland

2. DATE OF DEATH: March 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 409 Park Ave. 4-1

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M.	W.		Feb. 28, 1874	75 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
gardner		Prince George Co., Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel H. Freeland	Mary Rawlings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Miss Maud M. Freeland	St. 110 W. Mulberry

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 10 weeks ±

DUE TO

(B) Arteriosclerotic Cardiovascular Disease ?

DUE TO

(C) Hypertensive Cardiovascular Disease ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 25, 1949, *to* March 1, 1949, *that I last saw the deceased alive on* March 1, 1949, *and that death occurred at* 7:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Betty May Young M. D.	Maryland General Hospital	3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/4/49	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 3 - 1949	Assistant for Williams, Registrar	WM. J. TICKNER & SONS	Balto., Md.

VS 150

937

correct age is especially important. Physician - please write the cause

G720c7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 x 1

Registered No. G720c7

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Green

2. DATE OF DEATH: 3/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: 25 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): I20[illegible]. Caroline St. 3-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Sep.	3/15/1912	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		North Carolinia	U.S.A.

13. FATHER'S NAME: Ceza Green

14. MOTHER'S MAIDEN NAME: Mary Fo[illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Revis Moore ADDRESS: I6I5 Waldo St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteio-sclerotic P.V.

DUE TO

(B) Pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L Royer M.D

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 3/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/4/1949	Mt. Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 3 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25 FUNERAL DIRECTOR: Elroy O. wilson ADDRESS: I000 Brantly Ave.

correct age is especially important. Physician, please write the causes of death clearly.

VS 151

937

G72078

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1

G72078

Registered No.

BIRTH NO

1. NAME OF DECEASED (Type or Print) HAMMAR, MISS MARY ALICE

2. DATE OF DEATH MARCH 1, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland Home for Incurables 700 W. 40th Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Home for Incurables of Baltimore, Md.

c. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 142 W Lanvale St. U-2

5. SEX Female
6. COLOR or RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH JAN. 6, 1880
9. AGE (In years last birthday) 69 If under 1 Year: Months Days If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse
10B. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) BALTIMORE Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JOHN M. HAMMAR
14. MOTHER'S MAIDEN NAME ELIZABETH MARTIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT S.E. Ross ADDRESS 700 W 40th Street City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Occlusion	18 Hours
DUE TO (B)	Hypertensive Cardio-Vascular Disease.	1 Yrs.
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Old Hemiplegia (Left)	4 Mos

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December 1, 1948 to March 2, 1949, that I last saw the deceased alive on 3/2 1949 and that death occurred at 10:42 a.m., from the causes and on the date stated above.

23A. SIGNATURE W. Grafton Hersperger M.D.
23B. ADDRESS 214 Medical Arts Bldg
23C. DATE SIGNED 3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Mgmt-3-49
24C. NAME OF CEMETERY OR CREMATORY London Park
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR MAR 3 - 1949
REGISTRAR'S SIGNATURE Huntington for Williams, M.D.
25. FUNERAL DIRECTOR Stewart Morris Co - ADDRESS Balto Md

VS 150

93D

correct age is especially important. Physicians, please

G72069

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

490

Registered No. G72069

1. NAME OF DECEASED (Type or Print): Alexander Hawkins

2. DATE OF DEATH: 2/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore city Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1821 N. Caroline St.

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept.? 1893
9. AGE (In years last birthday): 55 | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work, done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): S C
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Korsome Hawkins
14. MOTHER'S MAIDEN NAME: Mariah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 215-01-2709
17. INFORMANT: Jamie Hawkins ADDRESS: 1821 N Caroline St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar pneumonia
DUE TO

ANTECEDENT CAUSES
(B)
DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 3/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/5/49
24C. NAME OF CEMETERY OR CREMATORY: A A Co. Mel
24D. LOCATION (City, town, or County) (State): Mt Calvary

DATE RECEIVED BY LOCAL REGISTRAR: MAR 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Robert Williams ADDRESS: 1515 Mt Calvary Av

VS 151

108

correct age is especially important. Physician, please write the

G720.0

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G720.0

1. NAME OF DECEASED (Type or Print) WILLIAM KEENE

2. DATE OF DEATH Feb. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 719 Rutland Avenue 7-5

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH August
9. AGE (In years last birthday) 50
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY Janitor
11. BIRTHPLACE (State or foreign country) Balto Md
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Alfred Keene
14. MOTHER'S MAIDEN NAME Melvina Keene

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-16-8099
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* ~~natural causes~~ ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE Emil L. Rey M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED Feb. 28, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE March 1949
24C. NAME OF CEMETERY OR CREMATORY Baltimore
24D. LOCATION (City, town or county) (State) National Cemetery

DATE RECEIVED BY LOCAL REGISTRAR MAR 3 - 1949
REGISTRAR'S SIGNATURE Penelope for William
25. FUNERAL DIRECTOR Robert C. Williams
ADDRESS 15-15 McElderry St 94a

VS 151

correct age is especially important. Physician: please write the causes of death in terms

H M. 127176

G720.71

776

G720.71

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C.47-64703

1. NAME OF DECEASED (Type or Print): Baby Girl Myers (mother Bernadine Myers)

2. DATE OF DEATH: Feb. 28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 930 Bennett Place 18-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 1 day: Hours / Min.
F	N	Single	Feb. 28-1949			10½

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME: George Hatchett

14. MOTHER'S MAIDEN NAME: Bernadine Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Records Balto City Hospitals 4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Prematurity	10½ Hrs.
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Feb. 27- , 1949, *to* Feb 28 , 1949, *that I last saw the deceased alive on* 2-28-49, 19 , *and that death occurred at* 6:20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. S. Rogers M. D.	B.C.H. 4940 Eastern Ave	3-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	March 2, 1949	Balto City Hospitals	4940 Eastern Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 3 - 1949	[illegible]	

VS 150

correct age is especial important. [illegible]

159

G720.72

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G720.72

1. NAME OF DECEASED (Type or Print): Sr. Mary Agnes [redacted] Lavin, R.S.M.

2. DATE OF DEATH: 3-2-'49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 55 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. (Mt. Washington)
D. STREET ADDRESS (If rural, give location): Mt. St. Agnes Convent 27-15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	S	[illegible]	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nun (Religious)		Georgia	U.S.

13. FATHER'S NAME: Not obtainable

14. MOTHER'S MAIDEN NAME: Not obtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Mercy Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast, rt. with Metastases — INTERVAL BETWEEN ONSET AND DEATH: 5yrs, +

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-5- 19[illegible], *to* 3-2- 19[illegible], *that I last saw the deceased alive on* 3-1- 19[illegible], *and that death occurred at* 6:55 *A.M.*, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. D. Thomas, Jr. M.D.	Mercy Hospital	3-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/4/49	Mt. St. Agnes	Mt. Washington Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
MAR 5 1949	Huntington Williams, M.D.	H. C. Mears and Son 805 N. Eutaw St

VS 150

50

correct age is especially important. Physician: please write clearly

G72073 44 ✓ G72073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print)	Moses Albert Levinson
2. DATE OF DEATH	March 3, 1949
3. PLACE OF DEATH: A.	Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	4515 Garrison Blvd.
c. Length of stay in Baltimore (Yrs. Mos. Days)	58 Years
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	4515 Garrison Blvd.
5. SEX	Male
6. COLOR OR RACE	White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	Single
8. DATE OF BIRTH	1878
9. AGE (In years last birthday) / If Under 1 Year Months Days / If Under 24 Hours Hours Min.	70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Lawyer
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	Russia
12. CITIZEN OF WHAT COUNTRY?	USA
13. FATHER'S NAME	Rabbi Abraham Levinson
14. MOTHER'S MAIDEN NAME	Jennie Abramson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	no
16. SOCIAL SECURITY NO	
17. INFORMANT ADDRESS	Dr. Frank Levinson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic nephritis — (INTERVAL BETWEEN ONSET AND DEATH) 4 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocardial insufficiency — 4 yrs

DUE TO

(C) Hypertension, arteriosclerosis — ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1948, *to* March 3, 1949, *that I last saw the deceased alive on* March 2, 1949, *and that death occurred at* 3:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	Frank Levinson	
23B. ADDRESS	4004 Liberty Hgts	
23C. DATE SIGNED	3/3/49	
24A. BURIAL, CREMATION, REMOVAL (Specify)	Burial	
24B. DATE	3-4-49	
24C. NAME OF CEMETERY OR CREMATORY	Bnai Israel Cong	
24D. LOCATION (City, town, or county) (State)	Baltimore, Md.	
DATE RECEIVED BY LOCAL REGISTRAR	MAR 3 1949	
REGISTRAR'S SIGNATURE	[illegible] Williams, M.D.	
25. FUNERAL DIRECTOR ADDRESS	S. Levinson & Bros 1124 W. North Ave	

correct age is especially important. Physician please

VS 150

1310

G720.4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 1-20-0 Registered No. G720.4

1. NAME OF DECEASED (Type or Print) REUBEN PINTZUK

2. DATE OF DEATH March 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 15-11
D. STREET ADDRESS (If rural, give location) 3327 Dolefield Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL of Baltimore

C. Length of stay in Baltimore 15 Years (Yrs. Mos. Days)

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH June 12, 1909 | AGE (In years last birthday) 39 | Under 1 Year: Months 8, Days 18 | Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mfg. Seat Covers | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Phila. Pa. | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Sol Pintzuk

14. MOTHER'S MAIDEN NAME Minnie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 160-03-8674

17. INFORMANT Cecile Pintzuk ADDRESS 3327 Dolgield Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 2, 1949, *to* March 2, 1949, *that I last saw the deceased alive on* March 2, 1949, *and that death occurred at* 5:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Aaron Sweed M. D. M. D. | 23B. ADDRESS Sinai Hospital of Baltimore | 23C. DATE SIGNED 3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3-4-49 | 24C. NAME OF CEMETERY OR CREMATORY Chizuk Amuno Cong | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 3 - 1949 | REGISTRAR'S SIGNATURE [illegible] | 25. FUNERAL DIRECTOR S. Levinson & Bros ADDRESS 1126 W North Ave

VS 150

correct age is especially important. Physician: please write plainly

93D

G7207.5

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G7207.5

1. NAME OF DECEASED (Type or Print): Nora May Hood

2. DATE OF DEATH: 3/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sydenham Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write M. R. A. and give township): Severn
D STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married.	Nov. 17-1887	61	3 15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Matthais Lowman
14. MOTHER'S MAIDEN NAME: Isabelle Redmiles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Hospital Chart ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Diabetic Acidosis	24 hrs
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) ~~Diabetes~~ Myocardial infarct from coronary occlusion Pneumonia, left lower lobe	?
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Diabetes diabetic acidosis	

over

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 3/2, 1949 to 3/2, 1949, *that I last saw the deceased alive on* 3/2, 1949, *and that death occurred at* 7:10 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sidney M. Cohen M. D.	Sydenham Hospital	3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/6/49	Nicholson Memorial Cem	Odenton, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 3 - 1949	[illegible]	T. W. Singleton - Glen Burnie	Md

VS 150

61

correct age is especially important. Physicians please write

G720.6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

G720.6

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print)	KATHRYN J. CASEY
2. DATE OF DEATH	Mar. 1, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	234 Park Ave.
C. Length of stay in Baltimore	Yrs. Mos. Days: 4-1
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Balto.
D STREET ADDRESS (If rural, give location)	234 Park Ave.
5. SEX	female
6. COLOR or RACE	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	single
8. DATE OF BIRTH	Aug. 8, 1888
9. AGE (In years last birthday) / If Under 1 Year: Months, Days / If Under 24 Hours: Hours, Min.	60 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	-
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	James Casey
14. MOTHER'S MAIDEN NAME	Kathryn Cummins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) / (If yes, give war or dates of service)	-
16. SOCIAL SECURITY NO	-
17. INFORMANT	Miss Elsie Fahndrich
ADDRESS	1204 Longwood St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, Right Kidney

DUE TO

(B) and Generalized Carcinomatosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: 4 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 15 *to* Mar. 1 19 49, *that I last saw the deceased alive on* Mar 1, 19 49 *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	John R Davis M. D.	23B. ADDRESS: Medical Arts Building
23C. DATE SIGNED	3/3/49	
24A. BURIAL, CREMATION, REMOVAL (Specify)	Burial	
24B. DATE	3/4/49	
24C. NAME OF CEMETERY OR CREMATORY	Lorraine Cem.	
24D. LOCATION (City, Town, or County) (State)	Woodlawn, Md.	
DATE RECEIVED BY LOCAL REGISTRAR	MAR 3 - 1949	
REGISTRAR'S SIGNATURE	Huntington Williams, M.D.	
25 FUNERAL DIRECTOR	WM. J. TICKNER & SONS	
ADDRESS	Balto., Md.	

correct age is especial important. Physician please

VS 150

52a

G7207.7 — BALTIMORE CITY HEALTH DEPARTMENT — 490 — G7207.7

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Vallie mae Sutton

2. DATE OF DEATH: March 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 654 W. Saratoga St.

c. Length of stay in Baltimore: 20 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-2
D. STREET ADDRESS (If rural, give location): 654 West Saratoga Stuet

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Single	Jan 1. 1914	35	2	7

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maid		Kinston N. C.	American

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Enoch Sutton	Sinna Fary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Edna Hargett 654 W Saratoga St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: One week

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Not Definite

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 22 , 1949 *to* Mar. 2, , 1949 *that I last saw the deceased alive on* Mar. 2, 19 49 *and that death occurred at* 6 p m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
Charles T Medlar	836 Harlem ave	Mar. 3, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/6/49		Kingston, N. C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 3 - 1949	Registrar for Municipality	Joseph A. Lively	66 W. Bone St

VS 150

108

correct age is especia... important. Physicia...

G7207 8 ✓ G7207 8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CAROLINE MAE SMALL

2. DATE OF DEATH: 3/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2302 W. Lanvale street

c. Length of stay in Baltimore: Lifetime (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-2
D. STREET ADDRESS (If rural, give location): 2302 W. Lanvale street

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Dec. 29, 1874
9. AGE (In years last birthday): 74 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Paul Ludwig
14. MOTHER'S MAIDEN NAME: Barbara Remlein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

(B) arterio Sclerotic type heart disease with cardiac hypertrophy & myocardial degeneration & insufficiency with congestive failure — 8 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): none
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1 1949 to March 1 1949 *that I last saw the deceased alive on* March 1, 1949, *and that death occurred at* 7.00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm Michel M. D.
23B. ADDRESS: 2901 Edmondson Ave
23C. DATE SIGNED: March 2/1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/4/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas. J. Evans & Son Inc
ADDRESS: 118 N. Mt. Royal Ave.

VS 150

correct age is especially important. Physician, please make

6720.79

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6720.79

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Esther Sara Dumas

2. DATE OF DEATH: 3-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Women's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: S. C.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Charleston
D. STREET ADDRESS (If rural, give location): 164 Wentworth St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W			70 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Russia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Read	Zelna Goldber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of Lung — 2 mos ?

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Generalized arteriosclerosis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-9-49, 19__, *to* 3-3-49, 19__, *that I last saw the deceased alive on* 3-3-49, 19__, *and that death occurred at* 10:42A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mark S. Hall, Jr. M. D.	Hospital Pottstown, Pa	3/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-4-49		Charleston, S. C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 3 - 1949	Huntington Williams, M.D.	Jack Lewis Inc.	2100 Eutaw Pl

VS 150

47D

correct age is especial importance. Physician please

G72080 ✓X G72080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59 ✓

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Andie Heilman

2. DATE OF DEATH 3/3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland St. Agnes Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hos

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. - U.S.A. B. COUNTY Balto

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Middle River

D. STREET ADDRESS (If rural, give location) 429 Edgewater Apts.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	white	married	2/27/1916	33 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Mass (Johnson)	

13. FATHER'S NAME L. B. Adams

14. MOTHER'S MAIDEN NAME Minnie L. Spell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.			Mr. C. Abram Snyder	Lancaster, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) TERMINAL UREMIA

DUE TO

(B) CHRONIC NEPHRITIS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/22, 1949, to 3/3, 1949, *that I last saw the deceased alive on* 3/3, 1949, *and that death occurred at* 1:20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
John H. Shaw M.D.	St. Agnes Hosp.	3/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Removal	3/4/49	Greenwood Cem.	Lancaster, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 3 - 1949	Florence [illegible] Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

1216

correct age is especially important. Physicia

B.C.H. 43761 G72081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 9-9-8 G72081 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PAUL SINCLAIR N-990. 2. DATE OF DEATH March 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 1627 N. Hilton Street 16-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
male	white	Single	3/21/46	2 SM				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
--		Baltimore, Md.	

13. FATHER'S NAME James E. Sinclair
14 MOTHER'S MAIDEN NAME Pauline Shoemaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT ADDRESS
		James E. Sinclair 1627 N.Hilton St.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation due to drowning
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES [x] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [x] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	public park	Franklintown Road 14/8 Gwynns Falls between Edmondson Ave. and

21D. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED WHILE AT WORK [ ]	NOT WHILE AT WORK [x]	21F. HOW DID INJURY OCCUR?
3	2	49	3p m.			Slipped and fell into Gwynns Falls

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [x] suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE H. J. McClafferty M.D
23B CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [x] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED March 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3-5-49	Loudon Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 3 - 1949	[illegible]	G. Howard Strong 3207 W. North Ave.,

VS 151

correct age is especially important. Physician: please write plainly

183

G72082

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72082

1. NAME OF DECEASED (Type or Print): Katherine Anna Boettinger

2. DATE OF DEATH: March 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1940 McHenry Street

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1940 McHenry St 70 C 3

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 21, 1875
9. AGE (In years. If under 1 year, last birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min.: 73 | 3 | 10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Boettinger
14. MOTHER'S MAIDEN NAME: Margaret Pfeifer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Elizabeth Weaver ADDRESS: 1940 McHenry St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: arterio sclerotic cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 14 yrs

ANTECEDENT CAUSES
(B) DUE TO: None
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(C) DUE TO:

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION: None
19B MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 2, 1947 to March 3, 1949, that I last saw the deceased alive on 3/3, 1949 and that death occurred at 8 a m., from the causes and on the date stated above.

23A. SIGNATURE: Benjamin Miller M.D. M.D.
23B. ADDRESS: 2030 Wilkens ave
23C. DATE SIGNED: 3/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 7, 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George L. Schwab ADDRESS: 2101 Frederick Ave.

VS 150

937

G72083

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72083

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nora May Buchta

2. DATE OF DEATH: Mar 2nd 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1619 N. Wolfe St

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1619 N. Wolfe St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 6
D. STREET ADDRESS (If rural, give location)

5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: 5/12/1889
9. AGE (In years last birthday): 59
If Under 1 Year: Months 9, Days 20
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: [illegible] Coles
14. MOTHER'S MAIDEN NAME: May

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Norman E. Buchta
ADDRESS: 2803 Edmondson Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — (Interval between onset and death) 5½ hrs.
DUE TO
(B) Coronary Occlusion — Same.
DUE TO
(C) Arteriosclerosis — 3 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 10, 1945 to Mar. 2, 1949, that I last saw the deceased alive on Mar. 2, 1949, and that death occurred at 4 A m. from the causes and on the date stated above.

23A. SIGNATURE: Ernest Levi, M.D. M. D.
23B. ADDRESS: 1605 N. Broadway
23C. DATE SIGNED: 3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/5/49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Park
24D. LOCATION (City, town, or county) (State): Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Wm Gott Inc. 127 St. Paul St.
ADDRESS

VS 150

94a

G72084

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. EE 16.4 Registered No. G72084

1. NAME OF DECEASED (Type or Print): LELAND ROCKWELL — N.804.2
2. DATE OF DEATH: March 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1234 Sulphur Spring Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Married	Oct 24 1905	43	4	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Builder	Contracting	Balto. Co. Md.	U.S.A.

13. FATHER'S NAME: Thomas H. Rockwell
14. MOTHER'S MAIDEN NAME: Rachel Cash
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. E. M. Rockwell ADDRESS: 1234 Sulphur Spring Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Concussion

DUE TO

(B) Multiple Fractures

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Public Highway	Sulphur Spring Rd & Wash. Blvd.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
March 3, 1949 12:58 a.m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Auto. & Auto. collision

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Emil H. Hoyer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 3-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	Lorraine	Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 4 - 1949	Huntington Williams, M.D.	Wm Cook, Inc. 127 St. Paul St.

VS 151

170c

#72085 9a.4162 ✓ G#72085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 450.0

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Cornelius K. Berger

2 DATE OF DEATH March 2. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2022 E. Hoffman St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Baltimore B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - Md
D STREET ADDRESS (If rural, give location) 2022 E. Hoffman St 8 07

5. SEX	6. COLOR OR RACE	7 SINGLE, MARRIED WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Married	Sept 6. 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
—		Baltimore. Md	U. S. A

13. FATHER'S NAME Frank C. H. Berger

14 MOTHER'S MAIDEN NAME Katherine M. Krause

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
none		Lydia E. Berger	2022 E Hoffman St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 23, 1949, *to* Mar. 1, 1949, *that I last saw the deceased alive on* MAR 1, 1949, *and that death occurred at* 11.55 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Victor Goldberg M.D	3108 Harford Road	3-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/5/49	Baltimore Cemetery	Baltimore. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 4 - 1949	Thelma Williams, M.D.	Howard N. Blight & Son	6009 Harford Road

VS 150

97

Correct age is especially important. Physician: please write

G72086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153 Registered No.

G72086

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH OLSHAN

2. DATE OF DEATH: 3-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEST BALTIMORE GENERAL HOSPITAL

c. Length of stay in Baltimore: 8 Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE: New York
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New York
D. STREET ADDRESS (If rural, give location): 1610 Clark Pl

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	1-7-79	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MUSICIAN	MUSIC STUDIO	Russia	

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			Harry Reberg	141 Ludlow St N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA COLON

DUE TO

(B) INTESTINAL OBSTRUCTION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) ACHD

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 8 DAYS

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
24 FEB. '49	CA COLON WITH INTESTINAL OBSTRUCTION	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 24 Feb, 1949, *to* 3 Feb, 1949, *that I last saw the deceased alive on* 3 Mar, 1949, *and that death occurred at* 11:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A Rowe M. D.	West Balt. Gen. Hosp.	4 March 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-6-49	Mount Ararat	Farmingdale L.I.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 4 - 1949	Thurlington for Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

46E

G720887

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 43 Registered No. G720887

1. NAME OF DECEASED (Type or Print): AMELIA KAUFMAN
2. DATE OF DEATH: MARCH 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTO.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 12-01
D. STREET ADDRESS (If rural, give location): 2450 CALLOW AVENUE

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1875
9. AGE (In years last birthday): 74 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fordousville Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Emanuel
14. MOTHER'S MAIDEN NAME: Betty
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Milton Kaufman ADDRESS: 2450 Callow Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HYPERTENSIVE CARDIO-VASCULAR
DUE TO HT. DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARTERIOSCLEROSIS
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: HYPERTROPHIC OSTEOARTHRITIS

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* MARCH 3, 1949, *to* MARCH 4, 1949, *that I last saw the deceased alive on* MARCH 3, 1949, *and that death occurred at* 6 20 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Barrett Berman M. D.
23B. ADDRESS: Sinai Hospital of Balto
23C. DATE SIGNED: 3-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-4-49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Hebrew
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

93

72038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

416

72038

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary E. Waller (also Mary E. Ensey)

2. DATE OF DEATH: 3-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq. Hosp.
c. Length of stay in Baltimore — 2 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Riviera Beach
D. STREET ADDRESS (If rural, give location): Wanda & Creek Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Married	7-6-1890	58 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HW		Md.	USA

13. FATHER'S NAME: John Reip

14. MOTHER'S MAIDEN NAME: Elizabeth Ruhl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—	—	Mrs. Ruth Babylon	1009 Poplar Grove St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic Heart Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic glomerulo-nephritis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 2-8 *, 19*49*, to* 3-2 *, 19*49*, that I last saw the deceased alive on* 3-2 *, 19*49*, and that death occurred at* 8 05 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. J. Laham, M. D.	Franklin Sq. Hosp	3-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
Burial	3/5/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 4 - 1949	Deputy for Williams, MD	WM. J. TICKNER & SONS	Balto., Md.

VS 150

Correct age is essential. Important. Typewrite or print plainly.

121R

G7208 ✓ 4777 G7208

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): CHARLOTTE SELLMAN CROOK HOUSE

2. DATE OF DEATH: Mar. 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3435 Mondawmin Ave.

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 3435 Mondawmin Ave. 15 38

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	June 8, 1859	89 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	

13. FATHER'S NAME: Columbus Crook

14. MOTHER'S MAIDEN NAME: Maria Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no	Mr. Ulyssus Grant House	3435 Mondawmin Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocarditis — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 days from Pneum. & Part 3 mo

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 28 *1949, to* March 2 *, 1949, that I last saw the deceased alive on* March 2 *, 1949, and that death occurred at* 5:40 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter Dunbar M. D.	2220 Harrison Blvd	March 4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/5/49	Greenmount Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 4 - 1949	for Williams, MD	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93E

correct age is especial importance. Typewrite or print plainly with pen and ink.

72090 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72090

1. NAME OF DECEASED (Type or Print): Josephine Haiden
2. DATE OF DEATH: 3/2/49
3. PLACE OF DEATH: A. Baltimore City, Maryland — 21 N. Mount St
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission): A. STATE — B. COUNTY: 21 N. Mount St
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 21 N. Mount St 19 02
c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F.	Col.	Widow	1895	54	-	-	-	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Richmond Co.	Ha.

13. FATHER'S NAME: Joseph Glasco
14. MOTHER'S MAIDEN NAME: Louise Lonnie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Ruth Mosley	21 N. Mount St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Uremia	1 week
DUE TO (B)	Hypertensive Cardio-Renal Disease	
DUE TO (C)	Senility	

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/1 1949 *to* 3/2, 1949 *that I last saw the deceased alive on* 3/2, 1949 *and that death occurred at* 3 P m *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ralph W. Redding M.D.	416 N. Johnson	3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/6/49	Richmond Co. Va.	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 4 - 1949	Huntington Williams, M.D.	Waterfield and Funeral Homes	927 W. Mount St

VS 150

1312

7-2091 To be approved ✓ 420.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH E903.

BIRTH NO. Registered No. G7-2091

1. NAME OF DECEASED (Type or Print) MRS. IDA V. FRANCE

2. DATE OF DEATH 3-2-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Calvert & 33rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) Pentridge Apts. 27 1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	W		12-1856	93	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Md.	USA

13. FATHER'S NAME John T. Cullimore

14. MOTHER'S MAIDEN NAME Esther Nelson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
	—	—	Daughter	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — (INTERVAL BETWEEN ONSET AND DEATH) —
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) ASHD
DUE TO
(C) Senility

CERTIFICATION APPROVED BY
Dr. Wm. Helfrich Rev
G. H. Merrill M. D.
CHIEF OR ASST. MEDICAL EXAMINER

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture, left femur

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12-21-48	Fracture, left femur	YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	—	Pentridge Apts.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
12 20 48 9 P.M.		Fall to floor while walking

22. *I hereby certify that I attended the deceased from* Dec 1st, 1948 *to* March 2, 1949, *that I last saw the deceased alive on* March 2, 1949, *and that death occurred at* 8:05 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
[signature] P. Mason M. D.	Union Memorial Hospital	3-2-49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	3-5-49	Greenmount	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 4 1949	Huntington Williams, M.D.	J. Stewart Hopwood Co.	Baltimore, Md.

VS 150

186a

G72092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 981.0 ✓

Registered No. G72092

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD WILSON N980.4

2. DATE OF DEATH February 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 206 West Ware Street 12-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 hours: Hours, Min.
male	Col.	Widow	Aug. 1879	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Md	USA

13. FATHER'S NAME Edward Willison

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Sadie Harris	204 Ware St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Shotgun wound of Rt. Chest

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	206 West Ware Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐	NOT WHILE AT WORK ☒	21F. HOW DID INJURY OCCUR?
2 28 49 9.25 P. m.			firearms

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil L. Kruger			March 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-5-49	Mt. Auburn	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 4 - 1949	Huntington Williams, M.D.	Mrs Kate R. Williams	322 N Schroeder St

correct age is especially important. Physicians: please write plainly.

VS 151

166

G72093

BALTIMORE CITY HEALTH DEPARTMENT 143

CERTIFICATE OF DEATH

G72093

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Catherine Morsell

2. DATE OF DEATH 2-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 848 S. Eutaw St

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. Maryland COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 848 S. Eutaw St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col.	Widow	Jan. 27, 1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Balto. Md.	U.S.A.

13. FATHER'S NAME Richard Morsell

14. MOTHER'S MAIDEN NAME Rachel McGuire

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		Mabel Commodore	848 S. Eutaw St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio Vascular Renal Disease — DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 6 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
not		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 22, 1949 *to* Feb 28, 1949 *that I last saw the deceased alive on* Feb 28, 1949, *and that death occurred at* 20 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. W. McDonald, M. D.	844 N. Carey St.	3/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-4-49	Arbutus Memorial Pk	Arbutus Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 4 - 1949	Huntington Williams, M.D.	Mrs Kate R Williams	322 N. Schroeder St.

VS 150

92D

72001. -126531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 330 Registered No. 72001

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Sheppard

2. DATE OF DEATH: March 1- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 32 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1105 W. Mulberry Street 18 0 0

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept.-8-1894
9. AGE (In years last birthday): 54 (If under 1 year: Months Days; If under 24 hours: Hours Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: James Sheppard
14. MOTHER'S MAIDEN NAME: Maggie Collins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT (Name and address): Balto. City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Sub Arachnoid Hemorrhage, Bilat. — INTERVAL BETWEEN ONSET AND DEATH: 11 Days
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

CERTIFICATION APPROVED BY
Dr. C. J. Lubinski per
G. A. Merrill M. D.
CHIEF OR ASST. MEDICAL EXAMINER

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Carcinoma of the Larynx — 2½ Yrs.

19A. DATE OF OPERATION: 8-21-46 + 8-28-46
19B. MAJOR FINDINGS OF OPERATION: Tracheotomy + Trachtomy 2-19-49 Bilatreal Transorbital lobotomy
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 25- , 1949 , *to* March 1- , 19 49 *that I last saw the deceased alive on* March -1 19 49 *and that death occurred at* 6.45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Hogan M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: March 2-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-5-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mrs. Katie R. Williams
ADDRESS: 312 N. Schroeder St.

VS 150

To Be Approved By Chief Medical Examiner 47a

G72095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 G72095 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clinton Bowden

2. DATE OF DEATH: March 2 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1624 Ashland Ave.

C. Length of stay in Baltimore: 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1624 Ashland Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Col.	Married	June 10, 1898	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Va.	

13. FATHER'S NAME: Richard Bowden

14. MOTHER'S MAIDEN NAME: Mary Frances

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Frances Bowden	1624 Ashland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Disease — DUE TO

(B) Congestive Heart Failure — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 1-4-49

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 4 1949 *to* March 2, 1949 *that I last saw the deceased alive on* March 2, 1949 *and that death occurred at* 3:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. K. Adams M. D.	1422 N. Caroline St	3-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	March 5/49		Blackstone Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 4 1949	Washington Williams, M.D.	Mrs. Ruth G. Elliott & Daughter	1129 N. Caroline St. 93

G72096 ✓ 1 G72096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Henry Burke

2. DATE OF DEATH: March 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1722 W Lanvale St
c. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1722 W Lanvale St 14 03

5. SEX: Male
6. COLOR or RACE: Cl.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 9 1895
9. AGE (In years last birthday): 53 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Theresa Burke — ADDRESS: 1722 Lanvale St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary disease of heart — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 24, 1949 *to* March 2, 1949 *that I last saw the deceased alive on* March 1, 1949, *and that death occurred at* 9:30a m., *from the causes and on the date stated above.*

23A. SIGNATURE: John E. S. Campfer, M. D.
23B. ADDRESS: 639 N. Carey St. Balto
23C. DATE SIGNED: 3-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 6/49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State): Arbutus Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 1949
REGISTRAR'S SIGNATURE: Penelope for Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Pott A. Elliott - Daughter — ADDRESS: 1129 N. Caroline St. 94a

Old G72097 — 581.0 G72097

BIRTH NO. G72097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): John Betch

2. DATE OF DEATH: MAR 2 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1325 S. Clinton St 2-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	9-24-82	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: John Betch

14. MOTHER'S MAIDEN NAME: Ella Bond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of liver
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-15- 1949 *to* 3-2- 1949 *that I last saw the deceased alive on* 3-2-49, 19____, *and that death occurred at* 6 a *m., from the causes and on the date stated above.*

23A. SIGNATURE: John Collins Harvey M. D. | 23B. ADDRESS: JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/5/49	Mt. Carmel	O'Donnell St.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS: Clarence F. Hoffmann 1639 Broadway

124 R

BIRTH NO. G72098

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72098

1. NAME OF DECEASED (Type or Print): Bernice Elva Caskey
2. DATE OF DEATH: June March 1, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland June 25
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 967 Stoll St.
c. Length of stay in Baltimore About 45 Yrs.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md — B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — June 25
D. STREET ADDRESS (If rural, give location): 967 Stoll St. 25-04
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married —
8. DATE OF BIRTH: March 12, 1894
9. AGE (In years last birthday): 54 — If under 1 Year: Months — Days — If under 24 Hours: Hours — Min. —
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife —
10B. KIND OF BUSINESS OR INDUSTRY: At Home —
11. BIRTHPLACE (State or foreign country): Howard County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Greenberry Johnson
14. MOTHER'S MAIDEN NAME: Catherine Barnes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Melville H. Caskey — ADDRESS (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary insufficiency (acute) — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Coronary arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1948 to Feb. 25, 1949, that I last saw the deceased alive on Feb 25, 1949, and that death occurred at 2:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Henry W. D. Hollis, M. D.
23B. ADDRESS: 3308 W. North Ave.
23C. DATE SIGNED: 3-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Mar. 5, 1949
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 - 1949
REGISTRAR'S SIGNATURE: Williams, M.D. 3-1-49
25. FUNERAL DIRECTOR: J. Howard Evans
ADDRESS: 5 Charles St. Ave. Baltimore 30, Md.

Pronounced dead at 6 P.M. 4:00

G72099

132-HP-17194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 3401 / Registered No.

G72099

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Patricia Ann Porter	Porter	2. DATE OF DEATH 3/3/49	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland	B. COUNTY Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sydenham Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	14-3
c. Length of stay in Baltimore 6 mos (Yrs. Mos. Days)		D. STREET ADDRESS (If rural, give location) 2129 Division St.	
5. SEX Female	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single.	8. DATE OF BIRTH Aug 7-1948
9. AGE (In years last birthday)	If Under 1 Year: Months 6 Days 27	If Under 24 Hours: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Norman Carter		14. MOTHER'S MAIDEN NAME Edith Smith.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Parents - ADDRESS 2128 Division St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumococcus Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 5 Days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES X NO
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/28, 1949 *to* —, 19— *that I last saw the deceased alive on* 3/3, 1949 *and that death occurred at* 2:30 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sidney M. Cohen M. D.	Sydenham Hospital	3/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/5/49	Mt Auburn	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 4 - 1949	[illegible]	Geo. G. Kelson 1303 Presstman St.

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 3698

1. NAME OF DECEASED (Type or Print): LOUIS DOWNS

2. DATE OF DEATH: 3-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1009 Strucker St.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1009 N. Strucker St. 16 or

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored	Married	9-1-1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Transport Steam Ship Co.	Baltimore Md.	U.S.A.

13. FATHER'S NAME: Len Downs

14. MOTHER'S MAIDEN NAME: Elmachasa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown	242-18-5045A	Bertha Downs	1009 Strucker St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Myocarditis	1 year
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-7-, 1948, *to* 3-3-, 1949, *that I last saw the deceased alive on* 3-2-, 1949, *and that death occurred at* 1 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank A. Saunders M.D.	1029 N. Strucker St.	3-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	Arbutus	md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 4-1949	Entries for Williams, Mgr.	Geo. W. Kelson	1303 Pleasant St.

VS 150

93E

G72101 4-1 G72101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) AUGUST KAMPHAUS

2. DATE OF DEATH MARCH-4-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1719 S CHARLES ST

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
1719 S CHARLES ST
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTIMORE MD
D. STREET ADDRESS (If rural, give location)
1719 S CHARLES ST 23 3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
MALE	WHITE	SINGLE	JULY-31 1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: NOT KNOWN
14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO: NONE
17. INFORMANT ADDRESS: KATHERINE KAMPHAUS-1719 S CHARLES ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Insufficiency
DUE TO
(B) Arteriosclerosis & Myocarditis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 days.

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Feb 27 '49 *to* March 4 '49, *that I last saw the deceased alive on* March 3 '49, *and that death occurred at* 5A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Julius C. Schlenck M. D.
23B. ADDRESS: 1337 S. Charles St.
23C. DATE SIGNED: 3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: MARCH-7-49
24C. NAME OF CEMETERY OR CREMATORY: HOLY CROSS
24D. LOCATION (City, town, or county) (State): Md Co

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 - 1949
REGISTRAR'S SIGNATURE: Lennington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Bernard C Hanke 121 E West St

VS 150

93 Y

Correct age is especially important. Please check.

G72:02 G72:02

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HELEN GRACE JONES

2. DATE OF DEATH: Mar. 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1220 E. North Avenue

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1220 E. North Ave. 9 08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	Sept. 3, 1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookkeeper	Lord Balto. Press	Baltimore, Md.	USA

13. FATHER'S NAME: Levinkatin Jones

14. MOTHER'S MAIDEN NAME: Elizabeth Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	215-05-4185	Miss Bessie E. Jones-1220 E.North Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Breast - left — INTERVAL BETWEEN ONSET AND DEATH: 3 years.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/28, 1949 *to* 3/2, 1949 *that I last saw the deceased alive on* 3/2, 1949, *and that death occurred at* 10 30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sol Smith. M. D.	1223 E. North Ave	3/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/5/49	Baltimore Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 4 - 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND

50

G72103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-20.0

G72103

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Mr. William Davis

2. DATE OF DEATH: 3-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: 25yr. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1611 Dundalk Avenue 2606

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 20, 1874

9. AGE (In years last birthday): 74 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tool Shop Attendant

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pittson, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John Wm. Davis

14. MOTHER'S MAIDEN NAME: Jane Anthony

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 213-09-3574

17. INFORMANT: Mrs. Maud Davis - ADDRESS: 1611 Dundalk Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Disease

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/23/ , 1949 *to* 3/2/ , 1949, *that I last saw the deceased alive on* 3/2/ , 1949 *and that death occurred at* 3:27 PM *from the causes and on the date stated above.*

23A. SIGNATURE: William R. Brashears M. D.

23B. ADDRESS: 1400 N. Caroline Street

23C. DATE SIGNED: 3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3/5/49

24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): North Ave. & Rose St.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 - 1949

REGISTRAR'S SIGNATURE: Evelyn for Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

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G72107 CERTIFICATE CORRECTED 3-18-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT 331 G72104

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ELIZABETH LILLIAM MINNICK

2. DATE OF DEATH March 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2728 E. Madison St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2728 E. Madison Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	widowed	July 29, 1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: Mrs. Madeline Klima - 2728 E. Madison St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — Interval between onset and death: 3-1-49
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO Generalized Arterio Sclerosis — Jan 1 '49
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY Ooccur? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/3 19 49 to March 2 19 49 that I last saw the deceased alive on 3/2 19 49, and that death occurred at 2-30 P.M. from the causes and on the date stated above.

23A. SIGNATURE William J. Rysavek M. D.
23B. ADDRESS 801 S Kenwood Ave
23C. DATE SIGNED 3/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Mar. 5, 1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): North Ave. & Rose St. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 4 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street

VS 150

83a

Dr. Gordy ✓ G72105

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. G72:05

CERTIFICATE OF DEATH

170 Registered No.

1. NAME OF DECEASED (Type or Print): SALLIE L. HIPP

2. DATE OF DEATH: Mar. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4222 Harford Terrece
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4222 Harford Terrace 9 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	May 30,1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Charleston, S. C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Reynolds
14. MOTHER'S MAIDEN NAME: ? Bolan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS: Mr. James O.Hipp,4222 Harfrd Terrace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I (A)	Carcinoma of Stomach	1 year
DUE TO (B)	Carcinoma of Breast	5 years
DUE TO (C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1944	Carcinoma of Breast, Removed	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO		none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Sept 20 *, 19*48*, to* March 2nd *, 19*49*, that I last saw the deceased alive on* March 2nd *, 19*49*, and that death occurred at* 3 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. L. Gordy M. D.	5106 Harford Road	3/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-5-49	Parkwood Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 4 - 1949	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

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G72106 G72106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Hoey 201 Registered No.

1. NAME OF DECEASED (Type or Print) ALBERT THOMAS

2. DATE OF DEATH 3/4/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST 6440. GEN. HOSP. ~~ROBERT THOMAS~~

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
d. STREET ADDRESS (If rural, give location) 8101 Old Harford Rd

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
M	W	single	10/23/1927	21		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Envelope Paper Cutter		Balto Md	

13. FATHER'S NAME Lee Thomas

14. MOTHER'S MAIDEN NAME Christine M. Hettchen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Father ADDRESS 8101 Old Harford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RESP. ARREST

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) HODGKIN'S DISEASE

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/1/49 *to* 3/5/49, *that I last saw the deceased alive on* 3/5/49, *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
J. D. Lambert M. D.	W Bolt	3/5/49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	3/7/49	Woodlawn	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 4 - 1949	Huntington Williams, M.D.	Leonard J. Luck	5305 Harford

VS 150

44C

G72107 151 G72107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Macy Ellen Sisk
2. DATE OF DEATH: 3-3-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2013 Penrose St.
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2013 Penrose St 20 01
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 6, 1883
9. AGE (In years last birthday): 65 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas Noonan
14. MOTHER'S MAIDEN NAME: ? Sullivan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Shirley Sisk ADDRESS: 2013 Penrose St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO

(B) Malnutrition — 1 yr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Carcinoma of stomach — 2 yrs.?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/10, 1949, *to* 3/3, 1949, *that I last saw the deceased alive on* 3/2, 1949, *and that death occurred at* 2:10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robt B. Wright M. D.
23B. ADDRESS: Mercy Ass't Bldg.
23C. DATE SIGNED: 3/4/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-5-49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George A. Farley, ADDRESS: Fulton Ave & Fayette St.

VS 150

46B

G72108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

156.2 G72108 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Wm. A. Caldwell Sr.

2. DATE OF DEATH: Mar. 2 - 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2037 Mura St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 56 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2037 Mura St. 807

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Oct. 20-1892	56	4	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Huckster		Balto. Md.	U.S.A.

13. FATHER'S NAME: Wm. J. Caldwell

14. MOTHER'S MAIDEN NAME: Ida Sanford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Edna E. Caldwell	2037 Mura St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthenia, etc. It means the disease, injury or complication which caused death.): Mucinous adeno carcinoma of liver Metastatic Carcinomatosis of liver
DUE TO: Source Undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
2/12/49	Punch Biopsy Liver - Mucinous adeno carcinoma of liver.	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/18, 1949 *to* 3/2/, 1949 *that I last saw the deceased alive on* 3/1, 1949 *and that death occurred at* 11:42 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Karl Grammar M.D.	1212 N. Patterson Park Ave.	3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar. 5-49	London Pk. Cem.	Frederick Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 4 1949	Lexington Williams M.D.	John A. Miller	2334 Jefferson St.

55E

G72109

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 G72109 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SOPHIA M. ROSENBERGER

2. DATE OF DEATH: 3/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5727 Ridgedale road

c. Length of stay in Baltimore: 64 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5727 Ridgedale road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	Widowed	4/16/ 1862	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Heinrich Heine

14. MOTHER'S MAIDEN NAME: Augusta Kaiser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	4 days
DUE TO (B)	Hypertensive Heart Disease	10 yrs.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July - 10, 1947, to - March - 1st, 1949, *that I last saw the deceased alive on* March 1st, 1949, *and that death occurred at* -10 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Earl L. Chambers M. D.

23B. ADDRESS: 4108 Liberty Hts. Ave

23C. DATE SIGNED: 3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3/5/49

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 1949

REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR: Chas D. Evans Son Inc

ADDRESS: 118 N. Mt. Royal Ave 93D

VS 150

G72110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72110

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Hutchinson Warfield

2. DATE OF DEATH: Mar 3rd 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1301 Park Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 128 W. Lafayette Ave 14 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
WF	W	Single	Oct 18 1863	85	4	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto., Md	

13. FATHER'S NAME: Daniel Warfield

14. MOTHER'S MAIDEN NAME: Mary Hutchinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Rebecca Warfield	4 Charlton St W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis, Arteriosclerosis — DUE TO — Gradual

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1930 *to* March 3, 1949, *that I last saw the deceased alive on* 3/3, 1949, *and that death occurred at* 10 45 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W R Keedy M. D.	1403 Park ave	3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 5 1949	Green Mount	Balto., Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 4 - 1949	Huntington Williams, M.D.	Henry W. Jenkins & Sons	4925 York Rd

VS 150

93D

72111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. 72111

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Sidney Sutherland

2. DATE OF DEATH: March 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4708 Keswick Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

C. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY: none
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 4708 Keswick Road 2 7 - 14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	September 4, 1878	70	5 - 29	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
real estate		Baltimore, Maryland	U.S.

13. FATHER'S NAME: Harry C. Sutherland

14. MOTHER'S MAIDEN NAME: Mary Mardaga

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Wilbur C. Sutherland - ADDRESS: 5868 Solway St. Pittsburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(B) Arteriosclerosis — 10 years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 1948 to MARCH 2, 1949, that I last saw the deceased alive on 3 - 2, 1949, and that death occurred at 1:30 A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Arthur Jones M. D.	8004 33rd St	3-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 5, 1949	Baltimore	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 4 - 1949	Huntington Williams M.D.	John O. Mitchell & Sons, Inc.-1900 Eutaw Pl

VS 150

John O. Mitchell

83a

G72:12

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72:12

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elinor Williams Baden

2. DATE OF DEATH: March 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 200 E. 34th St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

c. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 200 E. 34th St. 12-62

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
female	white	widowed	January 16, 1869	80	1 17	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Calvert County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Benson Robertson

14. MOTHER'S MAIDEN NAME: Ann Rebecca Allnutt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elinor Robertson Baden - ADDRESS: 200 E. 34th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Probable cerebral embolus.

DUE TO

(B) Cardio-vascular disease with myocardial insufficiency with auricular fibrillation.

DUE TO

(C) Generalized arterio-sclerosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: Unknown.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/25, 1946, *to* 3/31, 1949 *that I last saw the deceased alive on* 2/27/49, 19__, *and that death occurred at* 10:30 AM *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas R. Baden M. D.

23B. ADDRESS: 11 E. Chase St.

23C. DATE SIGNED: 3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 3/5/49

24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge

24D. LOCATION (City, town, or county) (State): Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Pl.

John O. Mitchell

VS 150

93D

G72133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Form No. 1

G72133

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE T. GORSUCH

2. DATE OF DEATH: 3/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 628 Dumbarton Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 628 Dumbarton Avenue 9 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
Male	White	Widowed	1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cabinet-Maker		Baltimore, Md.	

13. FATHER'S NAME: Louis C. Gorsuch

14. MOTHER'S MAIDEN NAME: Mary T. Geis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Helen P. Wright ADDRESS: 628 Dumbarton Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Thrombosis	10 days.
DUE TO	arteriosclerosis	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 15, 1949, *to* Mar 2, 1949 *that I last saw the deceased alive on* Mar 2, 1949, *and that death occurred at* 7:15 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lloyd E. Taylor M. D.	2902 Fremont Ave.	Mar 4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	3/5/49	Mt. Carmel Cem.	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 5 - 1949	Evangeline Williams, M.D.	WIEDEFELD & SON	~~GR MOUNT AVE & 22ND~~

VS 150

94a

G72114

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54-4 Registered No. G72114

1. NAME OF DECEASED (Type or Print): Ronald Burrier

2. DATE OF DEATH: MAR 4 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: WASH.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerstown
D. STREET ADDRESS (If rural, give location): Route #1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Infant			11 weeks	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Harold Burrier

14. MOTHER'S MAIDEN NAME: Nellie Angelberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cardiac failure	
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Congenital heart disease	Life
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/4 *1949, to* 3-4- *1949, that I last saw the deceased alive on* 3-4- *1949, and that death occurred at* 7.45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. E. Bond M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 7	Chapel	Mt Lebanon

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 5 - 1949	Huntington Williams, M.D.	G. C. Barton Hagerstown Md

VS 150

157E

G72115

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

592 Registered No.

G72115

1. NAME OF DECEASED (Type or Print): MARGARET CULMINGS SMITH

2. DATE OF DEATH: March 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4227 Potter Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4227 Potter Ave. 20-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Widow	Sept. 2, 1864	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Scotland	

13. FATHER'S NAME: James Muir

14. MOTHER'S MAIDEN NAME: Marion Bruce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No	None	William P. Hamilton, 4227 Potter Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Chronic Myocarditis	1 yr.
DUE TO (B)	Chronic Nephritis	1 yr.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 25, 1949 *to* March 3, 1949, *that I last saw the deceased alive on* March 2, 1949, *and that death occurred at* 7a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert Scagnetti, M. D.	1729 W. Lombard St	3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	Loudon Park.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 5 - 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

131a

G72116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

150

Registered No. G72116

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM H. JOHNSON

2. DATE OF DEATH March 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1702 Webster Street 24-54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
male	white		4/4/1887	61	11	0		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Worker	Ship Yard	Balto. Md.	

13. FATHER'S NAME Joseph W. Johnson

14. MOTHER'S MAIDEN NAME Maria Stafford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mary Brigerman	1702 Webster St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Esophagus — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ..... DUE TO

(C) .....

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Paul L. Reyer M.D.		March 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	Cedar Hill	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 5 - 1949	Huntington Williams, M.D.	Wm Cook Inc.	27 St. Paul St.

VS 151

46a

correct age is especially important. Typewrite or print plainly with

(17217) (17217) (17217)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

F 9240

Registered No. N-991

BIRTH NO. B.C. 49-03925

1. NAME OF DECEASED (Type or Print): Essie Jean Evans

2. DATE OF DEATH: March 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 104 N. Greene Street

4 days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Single	Feb. 10, 1949			23

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
------	------	Baltimore, Md.	U. S. A.

13. FATHER'S NAME: James A. Evans

14. MOTHER'S MAIDEN NAME: Essie Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		James A. Evans, 104 Greene St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Mechanical suffocation
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	104 N. Greene St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
March 3, 1949 ? a.m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Overlay of parents

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER [X] / MEDICAL INVESTIGATOR	23C. DATE SIGNED
[signature] M.D.		March 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	3/5/49	London	London, Kentucky

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 5 - 1949	Huntington Williams, M.D.	Tilhorn Funeral Home	27 E. 2nd St.

VS 151

182a

G72118

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72118

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWIN. P. FELLOWS

2. DATE OF DEATH: Mch 3 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL, BALTO. MD.

C. Length of stay in Baltimore: 16 Years / Months / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LANDT, MD.
D. STREET ADDRESS (If rural, give location): ROUTE #1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	JUNE 30, 1898	50 51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter, Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York City

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Fellows

14. MOTHER'S MAIDEN NAME: Florence Sans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardio-vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: approx 14 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis

DUE TO

(C) Coronary Artery Disease

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cystic Left Kidney, Old tuberculosis right lung.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Feb 15 1949 *to* March 3, 1949 *that I last saw the deceased alive on* March 3, 1949 *and that death occurred at* 8:15 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John N Buchanan M. D.	Mercy	3-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mch. 6-1949	Bethel Cemetery	Cascade Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 5 - 1949	Huntington Williams, M.D.	M L Evergreen Sons	Thurmont Md

VS 150

Correct age is especially important. Please

121a

G72119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72119

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARY GEORGE DOBIE

2. DATE OF DEATH: Mar. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3907 Fernhill Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3907 Fernhill Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	widowed	Feb. 22, 1857	92 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Dumfries, Scotland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert A. Duff

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: no

17. INFORMANT: Mr. Louis C.L'Archeveque ADDRESS: 3907 Fernhill Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arterio sclerotic cardio-vascular dis. — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. /

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 194_ *to* Feb. 25, 19 49 *that I last saw the deceased alive on* Feb. 25, 19 49 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Nachmann Davidson M. D. | 23B. ADDRESS: 401 Medical Arts Bldg. | 23C. DATE SIGNED: 4 March 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/5/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 5 - 1949

REGISTRAR'S SIGNATURE: Remington Williams, M.D.

25 FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

925

672120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V X E 949.8 672120

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ROBERT McMASTER BELL — N.990.

2. DATE OF DEATH March 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Foot of Block Street

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE North Carolina B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Raleigh

D. STREET ADDRESS (If rural, give location) 2619 Grant Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
male	white	Single	Sept 21 - 1927	21				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Seaman		Durham - N. Carolina	

13. FATHER'S NAME Charles Ralph - Bell -

14. MOTHER'S MAIDEN NAME Mildred Lynn -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	244-32-7546	Chas. Ralph Bell	Greensboro - N.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Drowning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	harbor	Foot of Block Street 3/2

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
found 3 1 49 2p. m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Probable accidental drowning

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE George G. Merrill M.D. — 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR [X] — 23C. DATE SIGNED March 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
	March 6 - 49	Hopewell A.R.P. Cemetery	Chester - So. Carolina

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 5 - 1949	Countersigned for Registrar, Md.	Ellsworth Funeral Home	3911 Liberty Heights

VS 151

Balto. 7 Md. 183

Collect age is especially important. Physicians, please write plainly.

G72121 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

450.0 — G72121 — Registered No.

1. NAME OF DECEASED (Type or Print): JOHN DAVIS

2. DATE OF DEATH: February 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 626 Hamburg Street W. 7 1-01

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8 DATE OF BIRTH: 10/15/1872
9 AGE (In years last birthday): 76 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Chesterfield -Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Davis
14. MOTHER S MAIDEN NAME: Susan Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 201-07-1536
17. INFORMANT: Alexander Carter — ADDRESS: 1103 Briscoe S t.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-Sclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Emil C. Kopp M.D.
23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Feb. 26, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/5/49
24C. NAME OF CEMETERY OR CREMATORY: Mount Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, City

DATE RECEIVED BY LOCAL REGISTRAR: MAR 5 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Josiah L. Brownson — ADDRESS: 108 W Montgomery St

VS 151

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G72122 BALTIMORE CITY HEALTH DEPARTMENT 422.1 G72122

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) HARRY M. ADAMS also Henry M. Adams
2. DATE OF DEATH Mar. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 716 Washington Blvd.
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 716 Washington Blvd. 2/01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	widower	Sept. 29, 1861	87 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Blacksmith	self	Emmittsburg, Md.	

13. FATHER'S NAME Edward Adams
14. MOTHER'S MAIDEN NAME Sarah -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no	Mrs. Mary L. Pryor	Alexandria, Va. 315 E. Howell Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C.V.D. — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B)
DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 4 1940 19 *to* Feb 4 19 49 *that I last saw the deceased alive on* Feb 4 19 49 *and that death occurred at* 10A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
B Hughstein M. D.	888 W. Lombard St	3.5.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	Westminster Cem.	Westminster, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 5 - 1949	Registrar's Signature	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93D

B.C.48-15138 CERTIFICATE CORRECTED 3-10-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49

G72123 Registered No. G72123

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Larry Simms

2. DATE OF DEATH: 3/3/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1420 Wilmer Court 14-0

3. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	C	Infant	7/2/~~1947~~ 1948		8	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None			

13. FATHER'S NAME: Edward Mullens

14. MOTHER'S MAIDEN NAME: Ada Simms

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Ada Simms 1420 Wilmer Court

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Upper Respiratory Infection

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/5/1949	Mt. Zion	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 5 - 1949	[signature]	Mrs. George H. Holland 1631 Druid Hill Ave.

VS 151

104a

Correct age is especially important. Physician, please write plainly.

G72124 754.4 G72124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 48-07895 Registered No.

1. NAME OF DECEASED (Type or Print): TIMOTHY S. FEEHLEY

2. DATE OF DEATH: March 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sydenham Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 604 South Quail Street 26-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white		April 7, 1948		10	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William H. Feehley
14. MOTHER'S MAIDEN NAME: Katherine Ferstermann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Wm. H. Feehley, ADDRESS: 604 Quail Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

(B) Congenital heart disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]
23C. DATE SIGNED: 3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 3-7-49
24C. NAME OF CEMETERY OR CREMATORY: ZION LUTHERAN CEM.
24D. LOCATION (City, town, or county) (State): STEMMER'S RUN, MD.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 5 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles S. Zeiler, ADDRESS: 901 S. Conkling St.

VS 151

157E

G72125 G72125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James A Lake

2. DATE OF DEATH: 3-2-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 822 N Mount St. 16-07

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 822 N. Mount St.

c. Length of stay in Baltimore: 33 yrs. (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Col.	Married	Feb. 13, 1897	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		West Indies Islands	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Andrew Lake	Martha ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No.		Florence Lake	822 N. Mount St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of Lung	
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-11, 1949 *to* 3-2, 1949 *that I last saw the deceased alive on* 3-2, 1949 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M Eusilano M. D.	803 N Fremont	3-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	3-6-49	Arbutus Memorial	Arbutus Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 5 - 1949	Washington Williams, M.D.	Mrs Hattie R. Williams	3224 Edmondson Ave

VS 150

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G72126 BALTIMORE CITY HEALTH DEPARTMENT G72126

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Julia W. Clark
2. DATE OF DEATH: 3-4-49
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 815 So. Ellwood Ave
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 815 So. Ellwood Ave 1-01
5. SEX: Female
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct. 22 1884
9. AGE (In years last birthday): 64 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Clark
14. MOTHER'S MAIDEN NAME: Ann Clark
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mary Severson ADDRESS 815 So. Ellwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinomatosis, abdominal	4 mo.
DUE TO (B)	Adenocarcinoma sigmoid	6 mo
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION: 11-3-48
19B. MAJOR FINDINGS OF OPERATION: Adenocarcinoma of sigmoid
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-3, 1948 *to* 3-4, 1949 *that I last saw the deceased alive on* 3-4, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: John J Gorsky M. D.
23B. ADDRESS: 1711 East ave
23C. DATE SIGNED: 3-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-7-48
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 6 - 1949
REGISTRAR'S SIGNATURE: Remington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Moran ADDRESS: 3000 E. Balt. St

VS 150

46E

B.C.H.-0474 G72127 ✓ G72127

BIRTH NO. Ida Cremeans

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

760.5 Registered No.

1. NAME OF DECEASED (Type or Print): Kenneth Michael Morfoot

2. DATE OF DEATH: 3-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2025 W. Fayette St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore: Yrs. — Mos. 2 -- Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 29,
D STREET ADDRESS (If rural, give location): 419 S. Augusta Ave. 2016

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M.	W.	Single	3-2-49		2	13 5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frederick Kenneth Morfoot	Joan Louise Clinedinst

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Inter-Cranial Hemorrhage
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pre-maturity 5¼ lb.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
3/2/49	Cesarean Section	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/2, 1949, *to* 3/4, 1949, *that I last saw the deceased alive on* 3/4, 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
William S. Womack M. D.		

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
BURIAL	March 5, 1949	Western	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 6 1949	Williams, M.D.	Harry H. Wuhs	4101 Edmondson Ave Balto. Md.

160a

G72128 G72128

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4343

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) FREDERICK HANS FOLTZ
2. DATE OF DEATH 3-3-1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 1104 Sergeant St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —
c. Length of stay in Baltimore 30 — Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md.
D. STREET ADDRESS (If rural, give location) 1104 Sergeant St 21-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
male	white	widowed	November 18 1874	74 yr		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	watchman	Philadelphia Pa	U.S.A.

13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME ? Hans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		213-01-4836A	Mrs Ethel Foltz	1104 Sergeant St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Organic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 19 —, 1949, *to* March 3 —, 1949, *that I last saw the deceased alive on* Feb 25, 1949, *and that death occurred at* 11:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chester Riley M. D.	2532 Edmondson Ave	3-3-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 7 1949	LOUDON PARK	BALTO. MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 6 1949	Thurlington Williams, M.D.	HARRY H WEAKE	4101 EDMONDSON AVE

95c

G72129 ✓ 6 10 G72129

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): William Wesley Opher

2. DATE OF DEATH: 3/3/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 219 S. Freemont Ave.
C. Length of stay in Baltimore: 1 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 219 S. Freemont Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 hours: Hours, Min.
Male	Col.	Single	11/2/1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Eastern shore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Opher
14. MOTHER'S MAIDEN NAME: Prissilla Montgomery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Stanley ADDRESS 1805 Edmondson ..ve.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hydronephrosis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertrophy of Prostate — ?
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Arteriosclerosis, Myocarditis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 21, 1949 *to* 3/3, 1949, *that I last saw the deceased alive on* 3/2, 1949, *and that death occurred at* 4:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: E. Walter Shervington M. D.
23B. ADDRESS: 701 N Carey St.
23C. DATE SIGNED: 3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/7/1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. arburn Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 5 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Elroy O. ..ilson ADDRESS 1000 Brantly ..ve.

93D

G72130

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 44

G72130 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Sadie Norris

2. DATE OF DEATH: 3-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Freeland
D. STREET ADDRESS (If rural, give location): RFD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	W	March 31, 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Md.	USA

13. FATHER'S NAME: John Bailey Norris

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic CVD c
DUE TO hypertension & sclerotic kidneys

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Gastro - intestinal Hæding etiology undetermined

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-1-, 1949, *to* 3-5-, 1949 *that I last saw the deceased alive on* 3-5-1949 *and that death occurred at* 7:35 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John H Lasser M. D.	University Hospital	3-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/8/49	Hampstead Cem.	Hampstead Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 6 - 1949	Huntington Williams, M.D.	J. Jacob Hartenstein	937 New Freedom, Pa.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Katharine Widener
2. DATE OF DEATH: 3/6/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland : Bon Secours Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp.
c. Length of stay in Baltimore: 31 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland COUNTY: CARROLL Westminster, Route 2.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Westminster
D. STREET ADDRESS (If rural, give location): Penna. Ave. Apt.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White		7/3/05	43 yr.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher.	Public Schools	Baltimore	U.S.A.

13. FATHER'S NAME: Milton Sullivan
14. MOTHER'S MAIDEN NAME: Anna M. Little

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. Stewart Widener ADDRESS: Westminster Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) generalized cancer

DUE TO

(B) Cancer in the Spine.

DUE TO

(C) Cardiac failure.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.		

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~or CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	Mch. 8. 1949	Krider's	Westminster Md. R.D.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 1949	Huntington Williams, M.D.	J. E. Myers Jr.	Westminster Md.

Carlos J. Castellanos M.D. 552

670 G72132

G72132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MRS. MARGARET G. COSTELLO

2. DATE OF DEATH 3/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE Md. B COUNTY Balto.
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Catonsville
D. STREET ADDRESS (If rural, give location) 8 FOREST DRIVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White		—	33		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore	

13. FATHER'S NAME Mr. Alfred J. O'Farrell

14. MOTHER'S MAIDEN NAME MARY G. FARRELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		James F. Costello	8 Forest Drive Catonsville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Post Partum Hemorrhage — Interval between onset and death: 2 hrs.
DUE TO Uterine atony
(B) multi. parity
DUE TO
(C) Pre. mature Separation of placenta

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/3 1949, *to* 3/4 1949, *that I last saw the deceased alive on* 3/4 1949, *and that death occurred at* 9:15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William S. Womack M. D.	Bon Secours Hospital	3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	New Cathedral	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 6 1949	waiting for Matthews, MD	H. O'Meara and Son	825 W. Saratoga

14612

G72133 — BALTIMORE CITY HEALTH DEPARTMENT — G72133

CERTIFICATE OF DEATH

BIRTH NO. — Registered No. N.952.0

1. NAME OF DECEASED (Type or Print): LAWRENCE STANISLAUS PADIAN
2. DATE OF DEATH: March 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: 20 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 32 West Pennsylvania Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	Sept. 28, 1872	76	3	6	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plummer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore County
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: John PADIAN
14. MOTHER'S MAIDEN NAME: Catherine Kelly
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Miss Ann Lindsay — ADDRESS: Towson Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral concussion & contusions. & shock.
DUE TO
(B) Head injury
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
H. F. Merrill M.D.
for: John R. Davis M. D.
CHIEF OR ASST. MEDICAL EXAMINER

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Towson, Maryland
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: March 4, 1949 2 30 p. m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR?: Fell down cellar steps

22. I hereby certify that I attended the deceased from 3 p.m. March 4, 1949, to 3 3/4 a.m. March 4 1949 that I last saw the deceased alive on March 4, 1949, and that death occurred at 3 3/4 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Barton E. Clemens M. D.
23B. ADDRESS: Union Memorial Hosp
23C. DATE SIGNED: 3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/8/49
24C. NAME OF CEMETERY OR CREMATORY: Monte Maria
24D. LOCATION (City, Town, or County) (State): Towson, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 6 - 1949
REGISTRAR'S SIGNATURE: [illegible] Registrar of Records, Md.
25. FUNERAL DIRECTOR — ADDRESS: H. H. Mears & Son, 805 N. Calvert St.

VS 150

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G72134 ✓ BALTIMORE CITY HEALTH DEPARTMENT G72134 94

BIRTH NO. 420.1 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Weisberg, Julius

2. DATE OF DEATH 3-4-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore LIFE Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1500 Jefferson Street 7-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	white	married	April 11, 1890	58	10 24	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Simon Weisberg

14. MOTHER'S MAIDEN NAME Rachel Seidman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Dora Weisberg ADDRESS 1500 Jefferson St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CONGESTIVE HEART FAIL.	3-4-49
DUE TO (B)	CORONARY Thrombosis	3-4-49
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-4 19 49 *to* 3-4 19 49, *that I last saw the deceased alive on* 3-4 19 49, *and that death occurred at* 7 00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Lester Stanley M. D.

23B. ADDRESS Sinai Hosp

23C. DATE SIGNED 3-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 3/6/49

24C. NAME OF CEMETERY OR CREMATORY Herbert Herring Rem

24D. LOCATION (City, town, or county) (State) Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR MAR 6 1949

REGISTRAR'S SIGNATURE [illegible] Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS S. Levinson & Bros. 1126 N North Ave.

VS 150

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G72135 ✓ G7213535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 4 3 Registered No.

1. NAME OF DECEASED (Type or Print) Isadore MILLER — 2. DATE OF DEATH 3-5-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai

C. Length of stay in Baltimore 25 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3629 Park Heights Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If years, last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married		49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repair
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Herman
14. MOTHER'S MAIDEN NAME Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Anna Miller ADDRESS 3629 Park Heights Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) LEUKEMIA — (Interval between onset and death) 4 WKS
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION LEUKEMIC INFILTRATIONS
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-13 1949 *to* 3-5 1949 *that I last saw the deceased alive on* 3-5 1949 *and that death occurred at* 7:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Leonard Katz M. D.
23B. ADDRESS Sinai Hosp
23C. DATE SIGNED 3-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 3-6-49
24C. NAME OF CEMETERY OR CREMATORY Rosedale
24D. LOCATION (City, town, or county) Balto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1949
REGISTRAR'S SIGNATURE [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc. ADDRESS 2100 Eutaw Pl

VS 150

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G72136

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4/20.1

G721367 6

Registered No.

1. NAME OF DECEASED (Type or Print): Alva E. Young

2. DATE OF DEATH: 3/3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Md. B. COUNTY:

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore — Yrs. Mos. Days:

D. STREET ADDRESS (If rural, give location): 530 Hanover St. 22-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
M	W	Married	July 29 1903	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Steward	Ship	California	

13. FATHER'S NAME: Workman

14. MOTHER'S MAIDEN NAME: — German

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	530-01-6679	Mrs. Dorothy A. Young	2216 E. Chase St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerotic cardiovascular disease — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
H. J. McClafferty M.D.	☒	3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	Baltimore Cemetery	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 6 1949	Lemington for Williams, Mgr	Howard N. Blight	6009 Harford Road

VS 151

Correct age is especially important. Physician, please write plainly.

93D

G72137 BALTIMORE CITY HEALTH DEPARTMENT G72137 37

BIRTH NO. CERTIFICATE OF DEATH 33 / Registered No.

1. NAME OF DECEASED (Type or Print): Adam Sucinski (Suczynski)

2. DATE OF DEATH: March 3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 407 S Collington Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
407 S. Collington Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
407 S. Collington Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Longshoreman		Poland	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
	215093346	Jozefa Sucinski	407 S. Collington Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	A) Cerebral hemorrhage	5 hours
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO B) Arteriosclerosis & hypertension	years
	DUE TO C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO		

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Mar 1, 1949 *to* Mar 3, 1949, *that I last saw the deceased alive on* Mar. 3, 1949, *and that death occurred at* 5.30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sigmund R. Nowak M. D.	408 S. Patterson Park Ave	Mar. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 7/49	Holy Rosary	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 6 1949	Huntington Williams, M.D.	Fred W. Ozarowski	1938 Eastern Ave

VS 150

83a

BIRTH NO. G72138

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 Registered No. 022138

1. NAME OF DECEASED (Type or Print): Mrs. Adeline V. Ford

2. DATE OF DEATH: March 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3511 Ash Street

c. Length of stay in Baltimore: 31 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3511 Ash Street 13-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	December 22, 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Maryland	USA

13. FATHER'S NAME: David C. Price

14. MOTHER'S MAIDEN NAME: Keziah --

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: John T. Ford ADDRESS: 3511 Ash Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 mth

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive C.V.D. Dis — several yrs.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus — several yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Mar 1, 1949 *to* Mar 3, 1949 *that I last saw the deceased alive on* Mar 3, 1949 *and that death occurred at* 7½ P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward H. Hausman M. D.	4037 Falls Rd.	3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 7, 1949	Poplar	Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR: MAR 8 1949

REGISTRAR'S SIGNATURE: [illegible] for Baltimore, Md.

25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

VS 150

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450.0 ✓

BIRTH NO. G72139

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72139

1. NAME OF DECEASED (Type or Print): Mary E. VonGerhardt

2. DATE OF DEATH: 3-5-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Univ. Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp. Greene & Lombard St.

c. Length of stay in Baltimore: 45 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D STREET ADDRESS (If rural, give location): 3644 Roland Avenue 13 6

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Jan. 2, 1861
9. AGE (In years last birthday): 88 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Forelady
10B KIND OF BUSINESS OR INDUSTRY: Knothe Brothers
11. BIRTHPLACE (State or foreign country): Maine
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Alonza Ramsdell
14 MOTHER'S MAIDEN NAME: Elizabeth Parsons
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 219-01-8849
17. INFORMANT: Mrs. Elizabeth J. Todd, ADDRESS: Portland, Maine

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia (etiology unknown (atypical ???)
DUE TO
(B) Cardiac failure
DUE TO
(C) Art. sclerosis (generalized)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 days - (6 yrs)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-1, 19 49 *to* 3-5, 19 49, *that I last saw the deceased alive* 3-5-49, 19 *and that death occurred at* 7 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Howard E. Hall M. D.
23B. ADDRESS: Univ. Hosp.
23C DATE SIGNED: 3-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 8, 1949
24C NAME OF CEMETERY OR CREMATORY: St. Mary's Hampden
24D LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: MAR 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

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G72140 BALTIMORE CITY HEALTH DEPARTMENT G72148

BIRTH NO. **CERTIFICATE OF DEATH** 50-1 Registered No.

1. NAME OF DECEASED (Type or Print): James Holland Chambers

2. DATE OF DEATH: March 4, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for the Aged of the Methodist Church

c. Length of stay in Baltimore: 72 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 W. Rogers Avenue

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 6, 1868

9. AGE (In years last birthday): 80 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman Retired 5 yrs.

10B. KIND OF BUSINESS OR INDUSTRY: Amer. Tobacco Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levi Chambers

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Holland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: ---

17. INFORMANT: Mrs. D. Estelle Chambers ADDRESS: 2211 Rogers Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I (A)	Myocardial degeneration	4 days
DUE TO (B)	Chronic Bronchitis	10 yrs.
DUE TO (C)		
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION:

19B MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE HOMICIDE (Specify):

21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 2 1949, *to* March 3 1949, *that I last saw the deceased alive on* March 3rd 1949, *and that death occurred at* 5:15 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Arthur J. Davies, M. D.

23B ADDRESS: 800 W 33rd St

23C DATE SIGNED: 3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: March 7, 1949

24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge

24D LOCATION (City, town, or county) (State): Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: MAR 6 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25 FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

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BIRTH NO. G72141

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 43 G72141

1. NAME OF DECEASED (Type or Print): Helen Marie Knox

2. DATE OF DEATH: March 3rd.,1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1829½ Caroline Street

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): I829 N.Caroline Street

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan.22,I886
9. AGE (In years last birthday): 63 (If under 1 year: Months I, Days I2; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Decorator
10B. KIND OF BUSINESS OR INDUSTRY: Pottery
11. BIRTHPLACE (State or foreign country): Baltimore,Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard T.Knox
14. MOTHER'S MAIDEN NAME: Mary Flynn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Miss Mary T.Knox,I829 N.Caroline St. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pericarditis — INTERVAL BETWEEN ONSET AND DEATH: 6weeks
DUE TO Carcinoma of breasts. General metasteses. — 6 Mos.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C) Fracture of Left Humerus. — 5 weeks

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1829 N.Caroline St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan.29,1949 10:45 A.M.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Striking arm against a buffet.

22. *I hereby certify that I attended the deceased from* Jan. 15, 1949 *to* March 3, 1949 *that I last saw the deceased alive on* March 3,1949, *and that death occurred at* 10:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry Singewald M. D.
23B ADDRESS: 1513 E.North Ave.
23C. DATE SIGNED: 3-4-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-7-49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D LOCATION (City, town, or county) (State): Edmondson Ave.Balto:Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George J.Ruth,Inc. I735 Harford Avenue (ADDRESS)

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 300.7

BIRTH NO. G72142 Registered No.

1. NAME OF DECEASED (Type or Print): Sister Alicia M. Ward

2 DATE OF DEATH: 3-5-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland ✓

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Institute

c. Length of stay in Baltimore: 21 Yrs. 2 Mos. 23 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Poughkeepsie, New York
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Poughkeepsie
D STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	white	single	4-15-1883	65	10	20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Religious Sister

10B. KIND OF BUSINESS OR INDUSTRY: school teacher

11. BIRTHPLACE (State or foreign country): Wilkesbarre, Pa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Ward

14 MOTHER'S MAIDEN NAME: Alicia Neison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: The Seton Institute ADDRESS: Baltimore, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Right cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 18hrs.

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Secondary anemia — 2 mos

Dementia Praecox — 28 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F HOW DID INJURY OCoccur?

22. I hereby certify that I attended the deceased from 3-5, 1949, to 3-5, 1949, that I last saw the deceased alive on 3-5, 1949, and that death occurred at 11 P m., from the causes and on the date stated above.

23A. SIGNATURE: Robert L. Meyers M. D.

23B. ADDRESS: Seton Institute

23C. DATE SIGNED: 3-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 3/6/49

24C. NAME OF CEMETERY OR CREMATORY: Scranton Pa.

24D. LOCATION (City, town, or county) (State): Scranton Pa.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 6-1949

REGISTRAR'S SIGNATURE: [illegible] for Williams

25. FUNERAL DIRECTOR: John J. Daley & Sons ADDRESS: 38 Light St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G72143 B.C.49-2486 (3) G72143 Registered No.

1. NAME OF DECEASED (Type or Print): EDWIN LUTTERSCHMIDT JR.

2. DATE OF DEATH: March 4, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mayland General

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. — Mos. — Days 3 wks.

D. STREET ADDRESS (If rural, give location): 2707 Lincoln Ave #19

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S

8. DATE OF BIRTH: 2/8/49

9. AGE (In years last birthday) / Under 1 Year Months Days / Under 24 Hours Hours Min.: 3 wks

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edwin Lutterschmidt

14. MOTHER'S MAIDEN NAME: Margaret Weld

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, left chest — INTERVAL BETWEEN ONSET AND DEATH: 7 days.

DUE TO

(B) Empyema, left chest

DUE TO

(C) Pericarditis, Peritonitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from 2/28/49 to 3/4/49, that I last saw the deceased alive on 3/4/49, and that death occurred at 7:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Charles J. Blocker M. D.

23B. ADDRESS: Maryland General

23C. DATE SIGNED: 3/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: March 7, 1949

24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn

24D. LOCATION (City, town, or county) (State): Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 6 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Roland L. Fisher, 2112 Dundalk Ave.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. [illegible]

1. NAME OF DECEASED (Type or Print) Elmer Wiles

2. DATE OF DEATH March 4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hospital

C. Length of stay in Baltimore Yrs. [illegible] Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Md.
D. STREET ADDRESS (If rural, give location) 3008 Darley Av. 12-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	April 23-1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME William B Wiles

14. MOTHER'S MAIDEN NAME Long

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	215-07-6465	Margaret B Wiles	3008 Darley Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cardiorespiratory Arrest	
DUE TO (B)	Chronic Lymphoid Leukemia	6 yrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 2 19 49 *to* March 4 19 49 *that I last saw the deceased alive on* March 4 19 49 *and that death occurred at* 7 55 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Daniel L. Silverstein M. D.	West Balto Gen. Hosp	3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 7-49	Lorraine Pk Cem.	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
		Frank H Seitz	814 N Eutaw St

MAR 5 1949 Huntington Williams, M.D.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72345

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas E. Spencer

2. DATE OF DEATH: Feb. 28-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3410 Hawkins Pt Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 3410 Hawkins Pt Rd

c. Length of stay in Baltimore — Yrs. / Mos. / Days

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1866
9. AGE (If over 1 year, last birthday): 82 — If under 1 year: Months / Days — If under 24 hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. ✓
17. INFORMANT: Susie Spencer ADDRESS: 3410 Hawkins Pt Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aneurysm abdominal aorta - ruptured — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO

(B) Arteriosclerotic Cardio-vascular disease — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 12, 1949 *to* Feb. 28, 1949, *that I last saw the deceased alive on* Feb. 26, 1949, *and that death occurred at* 5:40A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sidney R. Hebert, M. D.
23B. ADDRESS: 4700 Pennington Ave.
23C. DATE SIGNED: 3/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/6/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery
24D. LOCATION (City, town, or county) (State): Balto, Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, Mgr
25. FUNERAL DIRECTOR: Robert F. Williams
ADDRESS: 1515 McElderry St

VS 150

G72146 — 143 — G72146

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Anna L Schmidt

2. DATE OF DEATH: March 3rd 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospt

C. Length of stay in Baltimore: Yrs. 6 Mos. 6 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1633 N. Bradford St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Married	Aug 17th 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Germany	

13. FATHER'S NAME: Adam Karl Neubauer

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mrs Schmidt	1633 N. Bradford St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia
DUE TO
(B) Chronic Nephritis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
N Rosken M. D.	St Josephs Hospital	3-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 7th 1949	Baltimore	E North Ave Ext

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 6 1949	for Williams, M.D.	Leo Gudelsky	1701-03 N. Patterson Park Ave

937

BIRTH NO. G72147

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72147

1. NAME OF DECEASED (Type or Print): Edward Bottrell

2 DATE OF DEATH: Feb 25th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2075 Parkview Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rose M. Wilhelm Nursing Home

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D STREET ADDRESS (If rural, give location): 115 W. Mulberry St 4-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (If under 1 year last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	White	Widowed	1879	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Germany	

13. FATHER'S NAME: John Bottrell

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mr. Richardson Friend ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart

DUE TO

(B) Arteriosclerotic Myocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 19 49 *to* 25 Feb 19 49 *that I last saw the deceased alive on* 2/20 19 49 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
K. Traugott M. D.	1623 E. N. Ave	3/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Mar 6th 1949	St. Matthews Cem	O'Donnel St Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 5 1949	Lentington for Williams, M.D.	Leo D. Leo and Son	1701-03 N. Patterson Park Ave

MAR 5 1949
Dr. K. Traugott 1623 E. North Ave

93D

672148

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 672148 Registered No.

1. NAME OF DECEASED (Type or Print): PETER ROBERT BOXWELL

2. DATE OF DEATH: 3/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 637 E. Clement St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 637 E. Clement Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	W	II/27/1879	71	3	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Winchester, Virginia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William	Mollie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Family -	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	1 hr
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Hypertension -	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/4, 1949, *to* 3/4, 1949, *that I last saw the deceased alive on* Dec, 19 48, *and that death occurred at* 1 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. H. Goodman M. D.	3450 E Preston St	3/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	3/8/49	Macedonia	Winchester, Virginia

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 6 - 1949	Huntington Williams, M.D.	James L. McCully	130 E. Fort Avenue

VS 150

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BIRTH NO. G72149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

Registered No. G72149

1. NAME OF DECEASED (Type or Print): David Graham

2. DATE OF DEATH: Mar 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Franklin Sq Hosp.

C. Length of stay in Baltimore: 1 Day (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New York
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Freeport Long Island
D. STREET ADDRESS (If rural give location): 100 Maple Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W		Jan 31 1888	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): unknown
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Graham
14. MOTHER'S MAIDEN NAME: Clara —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wilbur Graham ADDRESS: Roosevelt L.I. N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage, Hypertension
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Autopsy / Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: Mar 5

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Mar 6 49
24C. NAME OF CEMETERY OR CREMATORY: Greenfield Cem.
24D. LOCATION (City, town, or county) (State): Hempstead N.Y.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 6 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Kettle ADDRESS: 4161 Edmondson Ave

Back 29 and 83a

V9-157

Correct age is especially important. Physician: please write plainly and fill in all blanks.

72150 ✓ B-72150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55

Registered No. G 72150

BIRTH NO.

1. NAME OF DECEASED (Type or Print)	ROSE G. KRUMM
2. DATE OF DEATH	Mar. 4, 1949
3. PLACE OF DEATH: A.	Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	Union Memorial Hospital
c. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	16-05
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	2430 W. Lafayette Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	Sept. 21, 1892	56	-	-		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	Baltimore, Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Gunterman	Mary Muller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		-	-

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinomatosis	3 mos.
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Carcinoma - probably Gall Bladder	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 26, 1949 *to* Mar. 4, 1949 *that I last saw the deceased alive on* Mar. 1949, *and that death occurred at* 4:30A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James McC. Zinsser M. D.	Union Memorial Hospital	Mar. 4, '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar. 7, '49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
Mar. 6, '49	Huntington Williams, M.D.	Harry H. Witzke, 4101 Edmondson Ave.

VS 150

46-F

G72151

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print) PHILLIPS, THOMAS A. | 2. DATE OF DEATH 3-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE
B. COUNTY Balto
SPRING GROVE STATE HOSPITAL CATONSVILLE MD
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) CATONSVILLE MD.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	DIVORCED	AUG. 8. 1865	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
COOK	STATE HOSPITAL	CARROLL COUNTY, MD.	U.S.A.

13. FATHER'S NAME: THOMAS A. PHILLIPS
14. MOTHER'S MAIDEN NAME: RACHAEL SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	—		VERLEY PHILLIPS	WESTMINSTER, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) BRONCHOPNEUMONIA

~~DUE TO~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CEREBROVASCULAR ACCIDENT

~~DUE TO~~

(C) ARTERIOSCLEROTIC CV DISEASE

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 12 DAYS

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-24 1949 *to* 3-6 1949, *that I last saw the deceased alive on* 3-6 1949 *and that death occurred at* 11:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Julia R Mausberger Jr M.D.	Univ. Hospital	3-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	MAR. 9, 1949	PROVIDENCE	GAMBER, MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 6 1949	Thurlow Williams, M.D.	J. FRANCIS REESE	WESTMINSTER MD.

93D

G72152 X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

G72152

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mr. George Wesley Duvall

2. DATE OF DEATH: March 4, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lenier Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: ~~Baltimore~~ CARROLL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sykesville, Md.
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	~~December~~ July 13, 1893	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attendant, State Hosp.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ulysses G. Duvall

14. MOTHER'S MAIDEN NAME: Berbennetta Holmes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT ADDRESS: Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 11 hrs.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertensive Cardiovascular Disease
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 4, 1949, *to* March 4, 1949, *that I last saw the deceased alive on* March 4, 1949, *and that death occurred at* 9 05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John R. Smith, Jr. M. D.

23B. ADDRESS: Union Memorial Hosp. Balto Md

23C. DATE SIGNED: 3-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3-7-1949

24C. NAME OF CEMETERY ~~OR CREMATORY~~: Wesley - Freedom

24D. LOCATION (City, town, or county) (State): Carroll Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 6 1949

REGISTRAR'S SIGNATURE: Evelyn Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: C. M. Waltz, Winfield. Md.

937

2153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 4.3 G72153

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Bessie Lewis

2. DATE OF DEATH 3 / 5 / 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore 4 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 329 East 27th St., Balt. 11 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	Wh.	(WIDOWED)	Feb. 27, 1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Maryland	U. S.

13. FATHER'S NAME William Frank Lewis

14. MOTHER'S MAIDEN NAME Lana Kolbe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Unkn.	—		Mrs. Ethel Johnson	Chester Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized arteriosclerosis

DUE TO

(C) Pericarditis — 6 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 1, 1949, *to* March 5, 1949, *that I last saw the deceased alive on* March 4, 1949, *and that death occurred at* 5:20 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John R. Smith Jr. M. D.	Union Memorial Hosp Balto Md	3.5.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	Parkwood	Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Huntington Williams, Mi	Wm Cook Inc	127 St. Paul St.

VS 150

8-2a

G721.54

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4th No. 1

G721.54

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) William E. Sines Jr

2. DATE OF DEATH March 4 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 778 S. Calhoun St

c. Length of stay in Baltimore 18 Yrs. 7 Mos. 15 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 778 S Calhoun St 19 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Aug 8. 1897	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Gen Co	Ohio	U S

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm E. Sines Sr	Agnes B. Cooly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	219-09-4956	Anna M. Sines	778 S. Calhoun St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Occlusion	Hours.
DUE TO (B)	Coronary Insufficiency	Several Months
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 25 1947 *to* Feb 28, 1949, *that I last saw the deceased alive on* Feb 28, 1949, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Abram Goldman M. D.	206 S. Gilmor St.	3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	March 7-1949	Glen Haven Cem	A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 1949	Huntington Williams, M.D.	Poff & B. M. Walton	Pratt & Chester Sts

VS 150

94a

G72155

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

G72155

Registered No.

1. NAME OF DECEASED (Type or Print): Mary Cooper

2. DATE OF DEATH: March 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1805 Brunt ST

C. Length of stay in Baltimore: Yrs. 20 years Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1805 Brunt St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	C	Married	Nov 25, 1920	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		S.C.	U.S

13. FATHER'S NAME: Willie Hyles

14. MOTHER'S MAIDEN NAME: Bessie Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Harvey Cooper ADDRESS: 1805 Brunt St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 2, 1949, *to* March 4, 1949, *that I last saw the deceased alive on* Mar. 4, 1949, *and that death occurred at* 4:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Julius S. White M.D.	1802 Penna Ave	3-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 7, 1949	Mt Auburn	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 1949	Huntington Williams, MD	George G. Nelson	303 Preston St

VS 150

823a

G72156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72156

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bernice Eads (Dorsey)

2. DATE OF DEATH: 3/2/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1435 Argyle Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. — B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (Or rural, give location): 1435 Argyle Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	C	W	9/4/1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
D		Md.	U. S.

13. FATHER'S NAME: John Dorsey

14. MOTHER'S MAIDEN NAME: Sallie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT — ADDRESS
		Eleanore Brooks 1435 Argyle Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular disease — DUE TO — (INTERVAL BETWEEN ONSET AND DEATH) 2 Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 19, 1947 *to* March 2, 1949 *that I last saw the deceased alive on* March 2, 1949 *and that death occurred at* 2-20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William H Watts M. D.	515 Johnston Sq	3/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	Arbutus	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
MAR 7 - 1949	Huntington Williams, M.D.	Geo. G. Kelson 1308 Pressman St.

VS 150

6

93D

G72157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

754

Registered No. G72157

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby Girl Humphreys

2. DATE OF DEATH: March 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 20 Maywell Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White					6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Bernard Humphreys	Margaret Ernest

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSP.	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Congenital heart disease	
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Prematurity	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P.H. Mansell M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar. 7-49	Cedar Hill Cem.	Ritchie Highway, Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Huntington Williams, M.D.	John A. Miller	2334 Jefferson St.

VS 150

157E

G72158

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

181 Registered No. G72158

1. NAME OF DECEASED (Type or Print): Mary L.(Marie) Valke

2. DATE OF DEATH: March 3,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 407 N.East Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ---
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 407 N.East Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 407 N.East Ave. 2 6 10

5. SEX	6. COLOR OR RACE	7. SINGLE MARRIED WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widow	Aug.13,1899	49	6 20	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---
10B. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Willard Espey
14. MOTHER'S MAIDEN NAME: Katie Herischmann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
---	---	---

17. INFORMANT: Mrs.Katie Espey ADDRESS: 407 N.East Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) GENERALIZED METASTASIS	2MOS.
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) ADENOCARCINOMA OF BLADDER (URINARY)	8 MOS.
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
DEC. 7, 1948	ADENOCARCINOMA OF URINARY BLADDER	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* NOV. 17, 1948, *to* MARCH 3, 1949, *that I last saw the deceased alive on* MARCH 3 1949, *and that death occurred at* 9.15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Highstein M. D.	121 S. HIGHLAND AVE.	MARCH 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar.7.1949	Baltimore Cem	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Huntington Williams M. D.	Philip Henry Sons	2024 Orleans St

VS 150

52B

G72159 ✓X G72159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Bertram, Robert Hooper

2. DATE OF DEATH Mar 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) United States Marine Hospital
c. Length of stay in Baltimore 4 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD, B. COUNTY Glen Burnie, Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glen Burnie
D. STREET ADDRESS (If rural, give location) 14 1st Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Sep 28, 1861	87				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USCG Lighthouse Sta.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) England. Jersey-Channel Isld.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Henry Charles Bertram
14. MOTHER'S MAIDEN NAME Eliza de le Taste
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO none
17. INFORMANT Frederick DeM. Bertram, ADDRESS Glen Burnie Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma, urinary bladder	
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Carcinoma, prostate	

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 3, 1948 *to* March 5, 1949, *that I last saw the deceased alive on* March 5, 1949, *and that death occurred at* 5.30A m., *from the causes and on the date stated above.*

23A. SIGNATURE Robert C Robyn M. D.
23B. ADDRESS U. S. Marine Hospital, Balto.
23C. DATE SIGNED Mar 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) CREMATION
24B. DATE MARCH 7, 1949
24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK
24D. LOCATION (City, town, or county) BALTIMORE, MD (State)

DATE RECEIVED BY LOCAL REGISTRAR MAR 7 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Thomas W Brighton
ADDRESS Glen Burnie Md

VS 150

51B

G72160

BALTIMORE CITY HEALTH DEPARTMENT 143 G72160

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) LILLIE M REDMAN

2. DATE OF DEATH 3/4/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3933 ROLAND AVE.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D STREET ADDRESS (If rural, give location) 3933 ROLAND AVE 12-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
FEMALE	White	MARRIED	5/31/1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	—	Md	

13. FATHER'S NAME —

14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—	—	—	OSCAR L REDMAN	3933 ROLAND AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO Hypostatic Pneumonia — 3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Congestive Heart Failure — Several days

(C) Hypertensive C. V. Dis — Several Years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCoccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/20, 1949 *to* 3/4/49, 1949 *that I last saw the deceased alive on* 3/4, 1949 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward L. Hyman M.D.	4037 Falls Rd.	3/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	3/7/49	ST MARYS	HAMPDEN

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Huntington Williams, Mgr	Paul E. Schwamb Jr. 345-17	Huntington Ave

FORM 1500

937

BB-127306

G72161

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4201 Registered No. G72161

1. NAME OF DECEASED (Type or Print) George Hitchens

2. DATE OF DEATH 3-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospitals

c. Length of stay in Baltimore 60 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 3026 Raynor Ave. 16-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Widowed	Dec. 13, 1869	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Good Will Ind.	Retired	Md	US

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	NO	RECORDS*BALTO CITY HOSPITALS	4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 40 Yrs.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

CERTIFICATION APPROVED BY
Earl John Davis M. D.
(SIGNATURE OF ASST. MEDICAL EXAMINER)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-4- , 1949, *to* 3-4- , 1949 *that I last saw the deceased alive on* 3-4- 1949, *and that death occurred at* 2:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
G. W. Chaffee M. D.	4940 Eastern Avenue	3-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	Loudon Park	Baltimore

DATE ACCEPTED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Huntington Williams, MD	John T. Stansbury	2700 Edmondson Ave.

VS 150

TO BE APPROVED BY MEDICAL EXAMINER.

93D

72162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 77 0. Registered No. 72162

1. NAME OF DECEASED (Type or Print): Arthur Jefferson

2. DATE OF DEATH: March 3, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1210 McCubbin Court Somerset Homes

c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 1210 McCubbin Court Somerset Homes 5 27

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored	Married	June 22, 1871	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	U. S. A.

13. FATHER'S NAME: Otter Jefferson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Mrs. Blanch Jefferson	ADDRESS: 1210 McCubbin Court

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypostatic pneumonia	4 days
DUE TO (B)	chronic atrophic arthritis	20 years
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 26, 1949, *to* March 3, 1949 *that I last saw the deceased alive on* March 3, 1949, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
R. W. McDaniel M. D.	507 N. Caroline St.	3-4-49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
	3-7-49	Mt. Auburn	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	[illegible] for Williams, M.D.	Mr. Frances R. Hemsley - W. Biddle	57[illegible]

VS 150

59a

G72163 ✓ 5021 G72163

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Miss ALICE MARGARET HUNTER

2. DATE OF DEATH: Mar 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland — B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp. Baltimore, Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: ? Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 3401 N. Calvert St 12 02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	W	S	July 29, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Personnelle

10B. KIND OF BUSINESS OR INDUSTRY: U.S.E.T.C.

11. BIRTHPLACE (State or foreign country): michigan

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: M. Hunter

14. MOTHER'S MAIDEN NAME: Caroline Wood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs Laura Hunter ADDRESS: 574 Huron St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tracheal obstruction — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Tracheitis — DUE TO — 3 weeks

(C) Pulmonary infarct — tracheotomy, 3½ yrs duration becoming cor. thyroidectomy and cord paralysis — 3 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-23-49 19__, *to* 3-5 19 49 *that I last saw the deceased alive on* 3-5 19 49, *and that death occurred at* 1 45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. R Coy 3d M. D.

23B. ADDRESS: Union Memorial Hospital

23C. DATE SIGNED: 3-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24B. DATE: Mar 7/49

24C. NAME OF CEMETERY OR CREMATORY: Greenmount

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 7 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Stewart & Mowen Co. ADDRESS: 108 W. North Ave

62D Baltimore, #1, Md.

VS 150

BIRTH NO. G72164

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72164

1. NAME OF DECEASED (Type or Print): Mary Bayless Massey.

2. DATE OF DEATH: Mar. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for Incurables

c. Length of stay in Baltimore: 3 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore, Md. B. ~~COUNTY~~ Homewood apt. 12-0
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	widowed	Aug. 5, 1864	84	6 / 26	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Harford Co. Md.	U.S.A.

13. FATHER'S NAME: Wm. F. Bayless

14. MOTHER'S MAIDEN NAME: Sara Hanna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT H.F.H. record ADDRESS
no		M. T. Owens, 700 W. 40th St., Balto. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Occlusion	4 Hours
DUE TO (B)	Arteriosclerosis (Generalized)	10 Years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Recurrent Cystitis	1 year
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Hypertrophic Arthritis	15 years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/3, 1946 *to* 3/4, 1949, *that I last saw the deceased alive on* 3/4, 1949, *and that death occurred at* 7:20 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Grafton Hesperger M. D.	214 Medical Arts Building	3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	3-8-49	Harmony Church	Harford County Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 1949	Evangeline Williams, M.D.	John C. Mitchell & Sons Inc. - M B Mitchell	1900 Eutaw Place

VS 150

940a

72165

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO.

43 G72165 Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH WILBOUR KIDD

2. DATE OF DEATH: 3/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cold Spring Nursing Home
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2136 Cliftwood Avenue 8 or

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 3, 1880
9. AGE (In years last birthday): 68 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: penna. R.R.
11. BIRTHPLACE (State or foreign country): Richmond, Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Kidd
14. MOTHER'S MAIDEN NAME: Laura Newell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: 717-07-7023
17. INFORMANT: Mrs. Carrie M. Kidd — ADDRESS: 2136 Cliftwood Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CEREBRAL HEMORRHAGE	3-1-49
DUE TO (B)	HYPERTENSIVE CARDIO-VASCULAR DISEASE	?
DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JAN 10, 1949 *to* MARCH 4, 1949, *that I last saw the deceased alive on* 3-3-, 1949, *and that death occurred at* 2150 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Norman R. Klemm M. D.
23B. ADDRESS: 3803 Edmondson Ave
23C. DATE SIGNED: 3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/7/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 7 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR — ADDRESS: HENRY SANDER & SONS, INC

VS 150

BALTIMORE - 13, MARYLAND 93Y

G72166

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 972.0
N 968.0

G72166 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Erma Hicks Taylor

2. DATE OF DEATH: March 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baiversity Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D STREET ADDRESS (If rural, give location): 803 W. Fayette Street 18 01

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: November 7, 1900
9. AGE (In years last birthday): 48 — If Under 1 Year: Months 3, Days 27, Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Calvert County Md
12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME: Samuel Jone Ford
14. MOTHER'S MAIDEN NAME: Charlotte Hicks
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Benjamin Taylor ADDRESS: 803 W Fayette St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation due to illuminating
DUE TO
gas

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 803 W. Fayette St.
21D TIME OF INJURY (Month) (Day) (Year) (Hour): March 4, 1949 ? m
21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F HOW DID INJURY OCCUR? Inhalation of illuminating gas (Two burners and oven on unlit)

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: C. J. Lubmeke M.D
23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C DATE SIGNED: March 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 10, 1949
24C. NAME OF CEMETERY OR CREMATORY: Arlington Memorial Park
24D LOCATION (City, town, or county) (State): Baltimore County Md

LOCAL REGISTRAR'S SIGNATURE: [illegible] 1949
REGISTRAR'S SIGNATURE: Lexington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph A. Sisly ADDRESS: 661 W Lane St

VS 151

163H

#72167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

401 1. G72167
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Dorothea Lineberger

2. DATE OF DEATH 3-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp Balt. Md.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 702 Warner Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Child	9-3-1934	14	5	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child		Baltimore Maryland	American

13. FATHER'S NAME Joseph Lineberger

14. MOTHER'S MAIDEN NAME Blanch Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Blanch Lineberger 702 Warner St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(A) Acute rheumatic [illegible]
DUE TO Effects of Rheumatic
(B) superimposed on [illegible] Rheumatic
DUE TO (C-V) [illegible]
(C) A Disease of the Lungs

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 3-2 1949 to 3-3 1949, that I last saw the deceased alive on 3-3 1949, and that death occurred at 8:15 A.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. B. [illegible] M. D.	University Hospital, Balt. Md.	3-4 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 8, 1949	Mount Calvary Cemetery	Anne Arundel County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
MAR 7 - 1949	Huntington Williams, M.D.	Joseph A. Lecky 661 West Baltimore St

VS 150

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G72168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 v r. 1

G72168

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) WILLIAM J. MORGAN

2. DATE OF DEATH March 4, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Nursing Home

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 27 N. Carey Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
male	white	Single	Aug. 12, 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Window Cleaner

10B. KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country) Balto. Md.

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John J. Morgan

14 MOTHER'S MAIDEN NAME Mary J. Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT ADDRESS Miss Edna Shanken, 3248 Wilkens Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE C. J. Pelmulder M D

23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED March 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE March 8/49.

24C. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery

24D. LOCATION (City, town, or county) (State) Homewood Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 7 - 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Harry H. Weitzle ADDRESS 4101 Edmondson Ave.

VS 151

937

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72169

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1 Registered No. G72169

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Conrad Valentine

2 DATE OF DEATH: 3/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SBG Hospital.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE
B COUNTY: 524 N. Castle
c CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	M	June 27-72	76 Yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Butcher	Butcher	Baltimore	

13. FATHER'S NAME: Anton Valentine

14 MOTHER'S MAIDEN NAME: Dont Know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
no		Hannah Valentine	524 N Castle

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Pulmonary Edema	12 hrs
	DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	Arteriosclerotic Cardiovascular Disease ?	
	DUE TO		
	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		Chronic Rt. Heart Failure	14 days

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 2/26, 1949, *to* 3/6, 1949, *that I last saw the deceased alive on* 3/6 1949, *and that death occurred at* 8:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Alex B. Gillis Jr. M. D.	SBGH	3/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	March 9th	Baltimore	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Washington Williams, M.D.	Ulrich Funeral Home	

VS 150

93)

G721.0 ✓ 450.0 G721.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Molly Fish
2. DATE OF DEATH: 3-6-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3405 Woodbrook Ave
c. Length of stay in Baltimore: 45 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3405 Woodbrook Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 77 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Isaac
14. MOTHER'S MAIDEN NAME: Chia
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Henry Fish ADDRESS: 3405 Woodbrook Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cardiac failure	1 month
DUE TO (B)	arteriosclerosis	3 yrs
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST — DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Has been a chronic invalid several years	

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.): ✓
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): ✓
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 25 19 49 *to* March 6, 19 49 *that I last saw the deceased alive on* March 6, 19 49, *and that death occurred at* 3:45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: I. Frederick Lack M. D.
23B. ADDRESS: Temple Gardens - Balto 17
23C. DATE SIGNED: 3/7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-7-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 7 - 1949
REGISTRAR'S SIGNATURE: Thomas Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

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#21.71

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450 ? G721.71

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BERTHA WASKINS

2. DATE OF DEATH 3-7-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4009 Springdale Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-10

c. Length of stay in Baltimore 60 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 4009 Springdale Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	widow		77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Russea	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Bernard	Debora

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Charles Waskins	4009 Springdale Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____ 19__ *to* ____ 19__, *that I last saw the deceased alive on* March 7, 19 49, *and that death occurred at* 1:45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. P. Brandt M. D.	3210 Liberty Heights Ave	3/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-9-49	United Hebrew	Washington Blvd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Remington for Williams, M.D.	Jack Levine Inc	

VS 150

97

G7217.2 Medical Examiner's case Eq#r.0 G7217.2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

N-864.1 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WOLTJEN, MRS. BLANCHE R.

2 DATE OF DEATH 5 MARCH '49.

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 15-10

D. STREET ADDRESS (If rural, give location) 3938 Dolfield Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Nov 2 1875	73	4 / 2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	Self	Pa.	

13. FATHER'S NAME Wm B. Rudy

14. MOTHER'S MAIDEN NAME Bella Schock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Chas. H. Woltjen	2728 W. Allegheny Ave Phila. Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rupture (traumatic), liver. — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

DUE TO

(B) Fall (8 ft) - from porch — 3 days

DUE TO

(C) Wm. H. Kammer, M.D. Pa

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
4 March '49	Rupture of liver	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home	3938 Dolfield Ave, Baltimore, Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
2 March '49 c 3P. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fell fr. porch while feeding birds 15-10

22. *I hereby certify that I attended the deceased from* 2 March, 1949, to 5 March, 1949, *that I last saw the deceased alive on* 5 March, 1949, *and that death occurred at* 5:35A *on*., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Joseph R. Dolce M. D.	Bon Secours Hospital	5 March 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Removal	3/8/49	Mount Carmel Cemetery	Mount Carmel Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Huntington for Williams, MD	Wm Cook Inc.	27 St. Paul St.

VS 150

186a

G72173 ✓ G72173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

491 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Nahool Kiel

2. DATE OF DEATH March 4, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 506 E. 35th St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 506 E. 35th St. 9-03 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months Days	If under 24 hours: Hours Min.
Male	White	Single	Apr. 5, 1888	60 11mos.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Checker	Terminal Warehouse	Maryland	US

13. FATHER'S NAME George A. Kiel

14. MOTHER'S MAIDEN NAME /

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Brother, Herbert Kiel	506 E. 35th

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from March 3, 1949, to March 4, 1949 that I last saw the deceased alive on Mar. 4, 1949, and that death occurred at 7:05 A.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bailey L. Doggett M.D.	3812 Greenmount Ave	March 4 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	3-8-49	Parkwood	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Registrar for Baltimore	John A. Moran	3000 E. Balt. St.

VS 150

107

72174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

17D Registered No. G72174

1. NAME OF DECEASED (Type or Print): Viola I. Schneller

2. DATE OF DEATH: 3-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 748 E. 36th St

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 748 E. 36th St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Married	4-29-1887	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	

13. FATHER'S NAME: Lewis G. Gorsuch

14. MOTHER'S MAIDEN NAME: Mary T. Geis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Frederick. W. Schneller

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Breast — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1948-Feb 9	Carcinoma of Breast	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__ *to* 3-3, 1949 *that I last saw the deceased alive on* 3-3, 1949 *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	3534 Eldorado Ave	3-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-7-49	Oaklawn	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	[signature]	John A. Moran	3000 E. Balt. St

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G721775

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B. 2. 49. 03426 — Registered No. G721775

1. NAME OF DECEASED (Type or Print): Baby Edward C. Harold
2. DATE OF DEATH: Nov. 6 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 28 rr Penna Ave

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Infant	2-21-1949		13	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Maryland	

13. FATHER'S NAME: Joseph Harold.
14. MOTHER'S MAIDEN NAME: Marie Flaig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	✓	Mrs. Joseph S. Harold	2822 Penna Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure from congenital heart lesion.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: minutes

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 3-4 1949 to 3-6 1949, that I last saw the deceased alive on 3-6 1949, and that death occurred at 12 m. p, from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sidney Johnson Venable Jr. M. D.	St. Agnes Hospital	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	New Cathedral Cem	4300 Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Interim Williams, M.D.	John J. Cowan & Son	2 Collins St

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157E

correct age is especially important. Physician: please write the

BIRTH NO. 152-49-045497 Koehle ✓X

Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G7217G

1. NAME OF DECEASED (Type or Print): Baby Koelle.

2. DATE OF DEATH: Mar. 2 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Philadelphia
D. STREET ADDRESS (If rural, give location): 5410 Trinity Pl.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): —
8. DATE OF BIRTH: Feb. 25 '49
9. AGE (In years last birthday): If Under 1 Year: Months: Days: 5; If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Ethel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) hemorrhage
DUE TO
(B) prematurity

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: over

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 25 *to* Mar 2 *, 19*49*, that I last saw the deceased alive on* Mar 2 *, 19*49 *and that death occurred at* 2 *m., from the causes and on the date stated above.*

23A. SIGNATURE: P.B. Salmon M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hosp. Disposal
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: MAR 7 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: ADDRESS:

VS 150

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Dr. Sawyer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. D 4 20 G72177

BIRTH NO. G72177

1. NAME OF DECEASED (Type or Print): LENA M. JONSKE

2. DATE OF DEATH: MAR. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2604 Southern Avenue

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2604 Southern Avenue 27-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	May 9, 1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Doerr	?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mr. Henry E. Jonske	2604 Southern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute Coronary Occlusion	1 day
DUE TO (B)	Arteriosclerotic Heart Disease	1 yr.
DUE TO (C)	—	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 10, 1948 *to* Mar. 4, 1949 *that I last saw the deceased alive on* Mar. 3, 1949, *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. Sawyer M. D.	4808 Harford Rd.	3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-7-49	Parkwood	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	[illegible]	Leonard J. Ruck,	5305 Harford Road.

VS 150

93D

Correct age is especially important. Physician: please write the cause of death plainly.

DR. KUNKOWSKI
7232[illegible] Beverly Rd.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓163 162 G72178

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Michael Charles Jurkowski -Yoursky

2. DATE OF DEATH: Mar. 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3015 Pinewood Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3015 Pinewood Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	Aug. 17, 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe Fitter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Jurkowski(Yoursky)

14. MOTHER'S MAIDEN NAME: Victoria ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 213-09-3142

17. INFORMANT: Mrs. Katherine Jurkowski, ADDRESS 3015 Pinewood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Carcinoma of Lung. Metastasis to Brain
(B) DUE TO: Hypercalcemia Incapacitating
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* March 5, 1949 *to* March 8, 1949 *that I last saw the deceased alive on* March 7, 1949 *and that death occurred at* 5:40 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Andrew Kunkowski M. D.
23B. ADDRESS: 2579 Eastern Av.
23C. DATE SIGNED: 3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-9-49	St. Stanislaus	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: MAR 7 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road.

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G7217'9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

HOME

G7217'9

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) PAUL ROLAND WEISHAAR

2 DATE OF DEATH 3-6-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore 2 MOS 10 DAYS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE MARYLAND B COUNTY CARROLL
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) KEYMAR RURAL
D STREET ADDRESS (If rural, give location) KEYSVILLE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	S	3-23-37	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ROY GRIFFIN RIPPEON

14. MOTHER'S MAIDEN NAME MISS MARY WEISHAAR ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Mother ADDRESS KEYMAR, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Arrest

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rheumatic heart disease

DUE TO

(C) Subacute Enterocolitis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 27 1948 *to* MAR 6, 1949 *that I last saw the deceased alive on* Mar 6 19 49 *and that death occurred at* 6 45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Francis J. Cattis M.D. M. D.

23B ADDRESS Union Memorial Hospital

23C DATE SIGNED 3-7-49.

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE MAR. 9. 1949

24C. NAME OF CEMETERY OR CREMATORY Baust Cemetery

24D LOCATION (City, town, or county) (State) Near Taneytown Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 7 - 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25 FUNERAL DIRECTOR J. O. Fuss Son ADDRESS Taneytown Md.

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G72180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4 20 1

G72180

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): SUDIE V SWEET
2. DATE OF DEATH: MARCH 6-1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 702 W HAMBURG ST.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
c. Length of stay in Baltimore: 7 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A STATE —; B COUNTY —; c CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE MD; D STREET ADDRESS (If rural, give location): 702 W HAMBURG ST. 7 21
5. SEX: FEM.
6. COLOR OR RACE: WHITE
7. SINGLE MARRIED WIDOWED DIVORCED (Specify): WIDOW
8. DATE OF BIRTH: Oct. 3-1869
9. AGE (In years last birthday) If Under 1 Year: Months Days If Under 24 Hours: Hours Min.: 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK.
10B KIND OF BUSINESS OR INDUSTRY: —
11 BIRTHPLACE (State or foreign country): VIRGINIA.
12 CITIZEN OF WHAT COUNTRY? —
13 FATHER'S NAME: NOT KNOWN.
14 MOTHER'S MAIDEN NAME: MARY CORDELL
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO —
17 INFORMANT: HYETT. T. BEANS. ADDRESS: 702 W. HAMBURG ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3-4 wks
DUE TO
(B) Myocardial infarction
DUE TO
(C) Coronary Artery sclerosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (Month) (Da) (Year) (Hour) m. | 21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR?

22 *I hereby certify that I attended the deceased from* Feb 15 *, 19*49*, to* March 6 *, 19*49*, that I last saw the deceased alive on* 3-6-49 *19 ___, and that death occurred at* 3.30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: C. E. Tangle M.D. M. D. | 23B ADDRESS: 642 North Blvd | 23C DATE SIGNED: 3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 24B DATE: 3-9-49 | 24C NAME OF CEMETERY OR CREMATORY: LOUDON PARK. | 24D LOCATION (City, town, or county) (State): FREDERICK. AVE BALTO MD

DATE RECEIVED BY LOCAL REGISTRAR: MAR 7-1949 | REGISTRAR'S SIGNATURE: Huntington Williams, MD | 25 FUNERAL DIRECTOR: Bernard G Harle | ADDRESS: 121 E West St

VS 150

94a

G72181

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72181

Registered No.

1. NAME OF DECEASED (Type or Print): STELLA LEWIS OSING

2. DATE OF DEATH: Mar. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 523 E. 22nd St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 523 E. 22nd St. 908

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.
female	white	widowed	Oct. 6, 1855	93 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Balto., Md.	

13. FATHER'S NAME: William Mansell Lewis

14. MOTHER'S MAIDEN NAME: Georgeanna Hunter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	no	Miss Blanche E. Osing	523 E. 22nd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute Coronary Occlusion	4 hrs
DUE TO (B)	Coronary Artery disease	5 yrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Generalized Arteriosclerosis	10 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 19[illegible] *to* March 3, 1949, *that I last saw the deceased alive on* March 3, 1949, *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas J. White M.D.	3809 Greenmount Ave	3-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	Greenmount Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	[illegible]	WM. J. TICKNER & SONS	Balto., Md.

VS 150

94a

G72182

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72182

1. NAME OF DECEASED (Type or Print): Ida Ruth Ambrose

2. DATE OF DEATH: Mar - 5 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. Women Maryland

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore Co
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Co
D. STREET ADDRESS (If rural, give location): 1607 N. Kilton Ave 11 ward

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Dec - 5 - 1896
9. AGE (In years last birthday): 52
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chambersburg - Penn
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Miller
14. MOTHER'S MAIDEN NAME: Laura Schultz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): unknown
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: Mrs M E Shank
ADDRESS: 611 Nottingham Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinomatosis	6 mos
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Carcinoma of breast	2½ yrs
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Diverticulosis	

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan - 27, 1949, *to* Mar - 5 -, 1949, *that I last saw the deceased alive on* Mar - 5 - 1949, *and that death occurred at* 3 30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: George H. Lefferson M.D.
23B. ADDRESS: Hosp. Women Maryland
23C. DATE SIGNED: Mar - 5 - 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Mar. 8, '49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 7 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS INC.
ADDRESS: North & Pa. Aves Balto. 17, Md.

VS 150

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MEDICAL EXAMINER'S CASE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 900.0 G72183 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES AUGUSTA WALTERS Sr. 443

2. DATE OF DEATH Mar. 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 431 N. Lakewood Ave.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M.	W.	Married	June 23 1876	72	8 / 13	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired.	Beth. Steel	Balto.	U.S.A.

13. FATHER'S NAME: William Walters

14. MOTHER'S MAIDEN NAME: Ann ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	None	218-10-6321	Annie F. Walters	431 N Lakewood Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro - vascular accident — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive arteriosclerotic

DUE TO

(C) Heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

CERTIFICATION APPROVED BY

Ford Wm. H. Kammer M. D.

CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident.	At. home	431 N. Lakewood Ave.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
3/3/49 at 1 P.M. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fell down steps (inside) sun

22. *I hereby certify that I attended the deceased from* 3/3/ , 1949 *to* 3/6/ , 1949 *that I last saw the deceased alive on* 3/6/ , 1949 *and that death occurred at* 10:30a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William R. Reed M. D.	1400 N. Caroline St.	3/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 9 1949	Holy Redeemer	4430 Belair Road Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Huntington Williams	Duffil Bros	1800 E Lombard St

MAR 8 1950

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G72184 903 G72184

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GERALD BLONDELL

2. DATE OF DEATH March 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

C. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 6 East 30th Street 12-02

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) about 61
If Under 1 Year: Months -- Days --
If Under 24 Hours: Hours -- Min. --

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10B. KIND OF BUSINESS OR INDUSTRY Int. Rev. Dept.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? ----------

13. FATHER'S NAME John A. Blondell
14. MOTHER'S MAIDEN NAME Margaret Burke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ----
(If yes, give war or dates of service) ----------
16. SOCIAL SECURITY NO. ----------

17. INFORMANT Edmund Blondell ADDRESS 3502 Newland Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

DUE TO

(B) Intracranial hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) In front of 6 E. 30th Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 2 24 49 m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fell to the sidewalk while intoxicated

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE [signature] M.D
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED March 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 3/8/49
24C. NAME OF CEMETERY OR CREMATORY New Cathedral
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR 1949
REGISTRAR'S SIGNATURE [signature] Registrar for Williams, M.D.
25. FUNERAL DIRECTOR H. H. Meare & Son ADDRESS 805 N Calvert St

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Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72185 BALTIMORE CITY HEALTH DEPARTMENT G72185

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): LAURA GRAY

2. DATE OF DEATH: 3/4/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 849 Hamilton Terrace

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 533 N. Calhoun St 1901

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Single	5/16/1887	61	9 / 16	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secty.		Baltimore, Md	U.S.A.

13. FATHER'S NAME: Charles Henry Gray

14. MOTHER'S MAIDEN NAME: Louise Poston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Louise C. Gray Jones	533 Calhoun St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Vascular Renal Disease
DUE TO
(B) undetermined
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. E. Langston

INTERVAL BETWEEN ONSET AND DEATH: unk

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 10, 1948 *to* Mch 3, 1949 *that I last saw the deceased alive on* Mch 3, 1949 *and that death occurred at* 10 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. B. Hughes M. D.	1413 Druid Hill Av	Mch 7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/7/49	Arbutus Mem'l. Pk	Balto. County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Huntington Williams, MD	Charles G. Cooper	512 N. Carrollton Av

VS 150

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G72186 ✓ G72186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33 ✓

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN F. BALD

2. DATE OF DEATH: 3/6/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — I4I9 Battery Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): I427 Battery Avenue 2 4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	M	4/3/I893	55	II 6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Court Of Com. Pleas.	Baltimore	

13. FATHER'S NAME: George

14. MOTHER'S MAIDEN NAME: Margaret Koch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Family - Same	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO

(B) Arteriosclerosis & Cyphotosis

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 15 49, to March 5, 49, *that I last saw the deceased alive on* March 4, 1949 *and that death occurred at* 5 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John C. Schwenck M. D.	1337 S. Charles St	3/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	3/8/49	Cedar Hill	Brooklyn, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	[illegible] for Philamena, M.D.	James L. McCarthy	- I30 E. Fort Ave.

VS 150

94a

G72187

BIRTH NO. G72187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72187

1. NAME OF DECEASED (Type or Print): ROSELLA HORNBERGER — 156 1

2. DATE OF DEATH: 3/5/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — I275 William Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): I400 William Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	M	3/15/1883	65	11 20	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Family -	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Cancer of liver

(B) DUE TO: Metastasis from Cancer Primary

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 Months

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[illegible] M.D.	107 E. West St	3/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	3/8/49	Baltimore -	E. North Avenue

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Huntington Williams, MD	James L. McCauley	6130 E. Fort Ave.

VS 150

46F

G72188 Dr Davis 3 Knollwood Rd Dundalk G72188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Marjorie Ruth Morrison

2. DATE OF DEATH: March 6,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6549 Parnell Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundolk, Baltimore
D. STREET ADDRESS (If rural, give location): 6549 Parnell Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	July 29,1909	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Wimmers, Pa.	

13. FATHER'S NAME: Eli Swingle

14. MOTHER'S MAIDEN NAME: Ester Oney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Alexander Morrison,	6549 Parnell Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular [illegible] 2 yrs
DUE TO Renal Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Dec. 17 1948 to March 6, 1949 that I last saw the deceased alive on March 4, 1949, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. D. Davis M.D.	Thanksgiving Dundalk	3/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	3/7/49	Saco	Pennsylvania

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 1949	Evelyn Williams, M.D.	William Cook, Inc.,	1217 St. Paul St.

131a

72189

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153

G72189

Registered No.

1. NAME OF DECEASED (Type or Print): Miss Elizabeth M. Hamer

2. DATE OF DEATH: March 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1019 S. East Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 1 Day: Hours	Min.
female	white	single	May 18, 1894	54	9	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore	

13. FATHER'S NAME: John Hamer

14. MOTHER'S MAIDEN NAME: Dora M. Hartman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		John Hamer	1019 S. East Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Adeno Carcinoma of Colon	?
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	(C)	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2/14/49	Adeno Carcinoma of Colon	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-10, 1949 *to* 3-4, 1949 *that I last saw the deceased alive on* 3-4, 1949, *and that death occurred at* 5½ p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard C. Hayden M. D.	Bon Secours Hosp	3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/8/49	Mt. Carmel	O'Donnell St.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Huntington Williams, M.D.	Clarence F. Hoffmann	1639 Broadway.

VS 150

46E

G72190

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

590

G72190

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Evelyn Quinn

2. DATE OF DEATH 2/28 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1125- E. Pratt St. 3 02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	Col.	Single	Feb. 1922	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed		Balto. Md.	U.S.A.

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no.

16. SOCIAL SECURITY NO

17. INFORMANT Mrs Louis Gomes ADDRESS 1126- Pratt

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Glomerulo-Nephritis DUE TO

ANTECEDENT CAUSES

(B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CONDITION LAST. DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection + Eng (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 2/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	3/7/49	Prov. Calvary	Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Huntington Williams M.D.	W. Halstead	918- Druid Hill Ave. 130

VS 151

cause and age is especially important. Physicians: please write the cause of death clearly and legibly.

Hovell

G72191 — BALTIMORE CITY HEALTH DEPARTMENT — 603 — G72191

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Hovell

2. DATE OF DEATH: 3/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4831 Park Heights Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

c. Length of stay in Baltimore: 48 (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	May 21, 1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	?	Penn.	U. S.

13. FATHER'S NAME: Alfred Hovell

14. MOTHER'S MAIDEN NAME: Lea Fry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-10-2443

17. INFORMANT: Hosp. Rec'd ADDRESS: Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pul monary Edema — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO

(B) Uremia & Acidosis

DUE TO

(C) Acute & Chron. Reud Shut Down

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Intestinal Obstruction

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
None		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-26, 1949 *to* 3-5, 1949, *that I last saw the deceased alive on* 3-5, 1949 *and that death occurred at* 7.10 *m. from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Whitehead Jr. M. D.	Church Home Hospital	3/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	3/9/49	Druid Ridge	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 - 1949	Hunter for Williams, M.D.	Loring Byers	5005 Park Heights Ave Balto 15, Md

VS 150

122 C

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 3-15-49

172:52

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

578 Registered No. 172:52

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Thomas Alexander

2. DATE OF DEATH March 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B COUNTY

C CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D STREET ADDRESS (If rural, give location)
3107 Gwynn Falls Pkwy

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W		Oct. 24, 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	-	Baltimore, Md.	USA

13. FATHER'S NAME
Thomas Alexander

14. MOTHER'S MAIDEN NAME
Annie ~~Loury~~ Lowry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No.	None	None

17. INFORMANT — ADDRESS
Mrs. Joseph H. Lawson — 414 N. Lakwood Ave. Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Massive G.I. Hemorrhage	12 hours
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) ?	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Cerebral Thrombosis	3 weeks

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 6, 1949, *to* March 7, 1949, *that I last saw the deceased alive on* March 7, 1949, *and that death occurred at* 2^25 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Betty May Young, M.D. M.D.	Maryland General Hospital	March 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/10/49	Lorraine Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
MAR 7 - 1949	Huntington [illegible]	WM. J. TICKNER & SONS Balto. Md. North & Pa. Aves.

VS 150

838

correct age is especially important. Physician: please write the cause of death clearly and legibly.

DUVALL

G72193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72193

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frank E. Duvall

2. DATE OF DEATH: March 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1118 N. Bond St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1118 N. Bond St.

C. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1118 N Bond St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored	Seperated	June 26 1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Duvall

14. MOTHER'S MAIDEN NAME: Frances ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes.
(If yes, give war or dates of service): World War 2

16. SOCIAL SECURITY NO:

17. INFORMANT: Alice Frasa ADDRESS: 1118 N. Bond St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — (Interval between onset and death): 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardio renal Disease. — ?

DUE TO

(C) Mitral insufficiency & nephritis — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 March 1949 to 6 March 1949 *that I last saw the deceased alive on* 6 March 1949, *and that death occurred at* 4.15 m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. C. Burwell M. D.

23B. ADDRESS: 921 Argyle St

23C. DATE SIGNED: 6 March 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: March 10/49

24C. NAME OF CEMETERY OR CREMATORY: Balto National Cem.

24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: MAR 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. Robert A. Elliott & Daughs ADDRESS: 1129 N. Carrollton St.

VS 150

131a

G72194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72194

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Richard Sands

2. DATE OF DEATH: March 6 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 16 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 412 Beechfield Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 7-12-1893
9. AGE (In years last birthday): 55 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Sec. Threads, American Oil Co.
11. BIRTHPLACE (State or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Sands
14. MOTHER'S MAIDEN NAME: Isabel Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Glomerulonephritis, chronic — INTERVAL BETWEEN ONSET AND DEATH: > 20 yrs.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes mellitus, mild

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/19 1949 *to* 3/4 1949, *that I last saw the deceased alive on* 3/4 1949, *and that death occurred at* 1:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE: John G. Hull M. D.
23B ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: March 6, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 3/7/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Montgomery, Alabama

DATE RECEIVED BY LOCAL REGISTRAR: MAR 7 1949
REGISTRAR'S SIGNATURE: Washington Williams, Reg.
25. FUNERAL DIRECTOR ADDRESS: George A. Farley - Fulton Ave & Fayette St.

Vs 1949

61

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G72195 Registered No. G72195

1. NAME OF DECEASED (Type or Print): Mc. Jo Nicholson Harris

2. DATE OF DEATH: March 6 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): St. Paul Apts. 101 E Mt. Royal Ave. 11-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	July 8 1869	80 79	7	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired - Railroad Man		Maryland	USA

13. FATHER'S NAME: R. Hopkins Harris

14. MOTHER'S MAIDEN NAME: Helen Nicholson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Robt. F Brent	St Paul Apts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral embolism — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardio Vascular Disease — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 4 1949 *to* March 6, 1949, *that I last saw the deceased alive on* March 5, 1949, *and that death occurred at* 3 00 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. C. Hoagland M. D.	Union Memorial Hospital	3-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	May 8 1949	Green Mount	Balto., Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 1949	Huntington Williams, M.D.	Henry W. Jenkins & Sons Co	4920 York Rd

VS 150

93D

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

72196

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 72196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1234 GLYNDON AVE.
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 95

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 GLYNDON AVE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME KAZIMIER KUPRUNAS (CHARLES COOPER)

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 219-12-6346

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife TEKLA
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Dec 1, 1877

8. AGE: Years	Months	Days	If less than one day
71	2	3	10¾ hr. ... min.

9. Birthplace Lithuania
(Town, county, and state)
10. Usual Occupation TAILOR.
11. Industry or business Retired.

FATHER
12. Name JONIZAS KUPRUNAS
13. Birthplace LITHUANIA

MOTHER
14. Maiden Name ELIZABETH MIKOLAITIS
15. Birthplace LITHUANIA

16 (a) Informant TEKLA Cooper
(b) Address 1234 GLYNDON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-8-9 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Charles W Eschenbach
(b) Address 703 McHenry St.

MAR 7 - 1949 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4 1949 at 10.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16 1948 to 3-4 1949 and that I last saw him alive on 3-4 1949.

Immediate cause of death	Duration
Pulmonary Effusion	10 hrs.
Due to Myocardial Infarction	1 month
Due to Chronic Myocarditis and Myocardial degeneration	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ueberth, Jr. M.D.
Address 1227 Wash. Blvd. Date signed 3-7-49 M. D.

VS 150

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information must be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G72197

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72197

1. NAME OF DECEASED (Type or Print): Howard J. Triplett

2. DATE OF DEATH: March 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Colonial Nursing Home
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 988 Franklintown Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widower	March 6, 1949	74	3	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: (Unknown) Triplett
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs Mary Triplett, ADDRESS: 988 Franklintown Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO
(B) Arteriosclerosis
DUE TO
(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Feb 19, 19__, *to* March 6, 19 49, *that I last saw the deceased alive on* 3/4/49, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Allen J. Cowen, M. D.
23B. ADDRESS: 612 Edmondson
23C. DATE SIGNED: 3/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/9/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 8 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: William Cook, Inc., ADDRESS: 1217 St. Paul St.

VS 150

937

G72198

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

33

G72198

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALICE S. MILLER

2. DATE OF DEATH: March 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1633 N. Rosedale St

C. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1633 N. Rosedale St 16-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	NOV 9 - 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore Md	

13. FATHER'S NAME: William F. Bragg

14. MOTHER'S MAIDEN NAME: Adele Nichols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	None	Adele J. Storm

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 1944 *to* March 6, 1949, *that I last saw the deceased alive on* March 5, 1949, *and that death occurred at* 9:25 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harris B. Schreiber M. D.	5 W. Fulton Ave.	3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 9-1949	Cedar Hill Cem.	A. A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 - 1949	Huntington Williams, M.D.	Robt C. & B. M. Walker	Pratt & Eastern

VS 150

836

Correct age is especially important. Physician: please write the name of death clearly and fully.

G72199 ✓X 211 G72199

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Thomas Edward Broadbent
2. DATE OF DEATH March 7, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Mass. B. COUNTY
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Bedford
c. Length of stay in Baltimore Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location) 278 Palmer St
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH 4-27-86
9. AGE (In years last birthday) 62 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer
10B. KIND OF BUSINESS OR INDUSTRY Institutional
11. BIRTHPLACE (State or foreign country) England
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Broadbent
14. MOTHER'S MAIDEN NAME Mary Hutton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Generalized peritonitis	5 days
DUE TO		
(B)	gangrene of sigmoid colon	7 days
DUE TO		
(C)	Vascular infarction following lap	8 days
	Angina pectoris - arteriosclerosis.	30 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2/26/49
19B. MAJOR FINDINGS OF OPERATION Polyp of sigmoid colon
20. AUTOPSY? YES ☒ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-20 1949 *to* 3-7 1949 *that I last saw the deceased alive on* 3-7 1949, *and that death occurred at* 9.50 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE W. J. Edgerton M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 3/8/49
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 3-8-49
24C. NAME OF CEMETERY OR CREMATORY Oak Grove
24D. LOCATION (City, town, or county) (State) Fall River Mass
DATE RECEIVED BY LOCAL REGISTRAR MAR 8 - 1949
REGISTRAR'S SIGNATURE Washington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Stewart Morris Bailey

VS 150

56E

G72200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 98 1.0 G72200 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) [illegible]ETT TURNER BURNS — N879.4

2. DATE OF DEATH March 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,

D. STREET ADDRESS (If rural, give location) 11 W. Mount Vernon Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Male	White	married	Oct. 31, 1910	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Brunswick, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wm. T. Burns, Sr.

14. MOTHER'S MAIDEN NAME Daisy A. Scott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 705-10-0996

17. INFORMANT Mr. Wm. R. Burns ADDRESS 964 Franklintown Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet wound of chest and abdomen

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) friend's home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 7911 Oakdale Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 3 6 49 5a.m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE Earl L Kay M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED March 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 3/9/49

24C. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 8 - 1949

REGISTRAR'S SIGNATURE [illegible]

25. FUNERAL DIRECTOR Wm. J. Dickey & Sons

ADDRESS Balto. Md.

VS 151

166

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72301 ✓ X G72301

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 171

Registered No.

1. NAME OF DECEASED (Type or Print): DOROTHEA C. CLOYES

2. DATE OF DEATH: Mar. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pineridge Nursing Home 6703 Hampnett Ave.
c. Length of stay in Baltimore: Yrs. 3½ mos. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B COUNTY: A. A. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pasadena P. O. (Sunset Beach
D STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
female	white	married	Oct. 20, 1904	44 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
housewife		Philadelphia, Pa.	

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
William Deeg	Wilhelmina Hoeffelmon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
		Mr. Philip W. Cloyes	Sunset Beach A. A. Co., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis

DUE TO

(B) Carcinoma of Cervix

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Thomas Brennan M. D.	5217 Harford Road	3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town or county) (State)
Burial	3/9/49	Glen Haven Cem.	A. A. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 8 - 1949	Registrar for Baltimore, Md.	Wm J. Zickner & Sons.	Balto., Md

VS 150

48a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72202

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72202

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dominick John Dugan

2. DATE OF DEATH: Mar. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR [illegible] (If not in hospital or institution, give street address or location): St. Joseph's
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 807 Melville Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M.	W.	Widowed	Aug. 10, 1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	U.S. Gov't. -	Baltimore	

13. FATHER'S NAME: Daniel Dugan.

14. MOTHER'S MAIDEN NAME: Bridget (?)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No.	-	None -	Mr. Edw. Dugan	807 Melville Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute coronary occlusion
DUE TO
(B) Arteriosclerotic Heart Lisease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Mar. 6, , 1949 *to* Mar. 7, , 1949 *that I last saw the deceased alive on* Mar. 7, 1949, *and that death occurred at* 4:09 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Philip A. Peter M.D. M. D.	1100 N. Caroline St., Balto. Md.	Mar. 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-11-49	Cathedral Cem.	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 - 1949	Huntington Williams, M.D.	Wiedefeld & Son	Greenmount Ave + 22nd

VS 150

93D

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BIRTH NO. 72203

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72203

1. NAME OF DECEASED (Type or Print): SARAH SRAGOVITZ
2. DATE OF DEATH: Mar 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3526 Greenspring Rd.
c. Length of stay in Baltimore: 42 Yrs. ___ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 3526 Greenspring Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	White	Widow		84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Latvia	

13. FATHER'S NAME: Reed
14. MOTHER'S MAIDEN NAME: Rowa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	1 day
DUE TO (B)	Cerebral Arteriosclerosis	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Coronary Sclerosis	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 26, 1949, *to* Mar 7, 1949, *that I last saw the deceased alive on* Mar 6, 1949, *and that death occurred at* 1:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Daniel L. Zalis, M. D.	1115 N. Calvert St	3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	3-8-49	United Hebrew	Balto	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 - 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

94a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72504

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72504

Registered No.

1. NAME OF DECEASED (Type or Print): Kitt, Morris

2. DATE OF DEATH: 3/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp.

C. Length of stay in Baltimore: 51 Yrs. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6107 Baltimore Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. If under 1 year, months, days. If under 24 hours, hours, min.)
M	W	M		82

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Russia	

13. FATHER'S NAME: Meyer

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Anna Kitt	6107 Baltimore Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Internal Hemorrhage

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-7 19 45 *to* 3-7 19 49 *that I last saw the deceased alive on* 3-7 19 49, *and that death occurred at* 9:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benton Steinberg M. D.	Sinai Hosp.	3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-8-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 - 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

103

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G72205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72205

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRY KOSTINSKY

2. DATE OF DEATH: 3-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2901 Oakley Ave

c. Length of stay in Baltimore: 37 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2701 Oakley Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	married		59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Butcher		Russia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamin	Lena

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Leoa Kostinsky	2701 Oakley Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Occlusion	1 day
	DUE TO (B) Hypertensive Cardio Vascular Disease	2 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 28, 1948 *to* March 7, 1949, *that I last saw the deceased alive on* March 7, 1949 *and that death occurred at* 10 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Milton E. Lowman M.D.	4843 Park Heights Ave	March 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-8-49	Hebrew Mt Carmel	Patto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

92 D

Please write the cause of death clearly and legibly. Physician: Please write the cause of death clearly and legibly. Physician: Please write the cause of death clearly and legibly. Physician:

G72.06

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72.06

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): JOHN MORGAN
2. DATE OF DEATH: March 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. General Hospital
C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY: Anne Arundel County
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): North Linthicum
D STREET ADDRESS (If rural, give location): Nursery Lane

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: April 14, 1878
9. AGE (last birthday): 70 years | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Florence Schwartz ADDRESS: 1319 Westphal Pl.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Arteriosclerotic cardiovascular disease with right hydrothorax and atelectasis of right lung.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCoccur?

22 *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George L. Merrill M.D
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-10-49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn, A.A.Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D
25. FUNERAL DIRECTOR: Geo L. Berger Jr ADDRESS: 512 Hollins St

VS 151

93)

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72.07

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 203

Registered No. G72.07

1. NAME OF DECEASED (Type or Print): Joseph A.Lehner

2. DATE OF DEATH: 3-6-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2812 Harford Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2812 Harford Avenue

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2812 Harford Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Married	Dec.25th.,1888	60	2	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Purchaseing Agent	Printing Co.	Baltimore	U.S.A.

13. FATHER'S NAME: John F.Lehner

14. MOTHER'S MAIDEN NAME: Caroline Scholl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 215-05-9696

17. INFORMANT: Mrs.Elizabeth R.Lehner 2812 Harford Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 10 Dys

(B) Ch Nephritis — DUE TO — 14 yrs

(C) Multiple Myeloma — 5 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mch 2, 19 49 *to* Mch 5, 19 49, *that I last saw the deceased alive on* Mch 5, 19 49, *and that death occurred at* 1 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ruth Y Ringer MD M. D.	2700 HARFORD RD	Mch 7 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-10-49	Holy Redeemer	Belair Rd.BaltoMd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 8 - 1949	[illegible]	George J.Ruth,Inc. 1735 Harford Avenue

MAR VS 150

55E

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

672-08

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

134.1 X

Registered No. 672-08

BIRTH NO.

1. NAME OF DECEASED (Type or Print) C. PAUL CLARK

2. DATE OF DEATH March 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Severn
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
male	white	married	October 30, 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer	farm owner	Severn, Maryland	

13. FATHER'S NAME
Wm. Handy Clark

14. MOTHER'S MAIDEN NAME
Coya Disney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		215-XX-3413	Mrs. Goldie Clark	Severn, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema
DUE TO
(B) Acute Congestive Heart Failure
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR	23C. DATE SIGNED
Earl L Royer M D		March 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/9/49	Glen Haven	Glen Burnie

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 - 1949	Evelyn Williams, M.R.	Thomas W. Leighton	Glen Burnie

VS 151

93E

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72209

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72209

1. NAME OF DECEASED (Type or Print): Edward Keyes

2. DATE OF DEATH: 3-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

C. Length of stay in Baltimore: 3 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hereford
D. STREET ADDRESS (If rural, give location): York Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W	S	Oct. 24 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	—	Maryland	U.S.

13. FATHER'S NAME: Lloyd Keys

14. MOTHER'S MAIDEN NAME: Eliza Bull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 218-14-9871

17. INFORMANT: Church Home & Hospital Records — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bladder Stone
DUE TO
(B) Peri-vesical abscess left
DUE TO
(C) Bilateral Pyelonephritis
DUE TO
(D) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2-22-49	Calculus in bladder	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-18, 1949, *to* 3-7, 1949 *that I last saw the deceased alive on* 3-7, 1949, *and that death occurred at* 1:25 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald W. Mintzer M.D.	Church Home & Hosp	3/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/10/49	Cedar Hill	A. A. Co.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 = 1949	Thurlington Williams, M.D.	Paul E. Clemente Jr.	3415 Eastern Ave

VS 150

1342

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72210 ✓ 190 G72210

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Del Roy Gilbert Parter

2. DATE OF DEATH: 6 March 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1205 Madison Ave

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1205 Madison 11 04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	C	S	22 Dec. 1933	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Md. USA	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Alfonso Parter	Bertha Hughes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mother	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pneumonia, lobar	10 days
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
None		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 26 Feb, 1941, *to* 6 March, 1949, *that I last saw the deceased alive on* 5 March, 1949, *and that death occurred at* 9:10 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ben B Watson Jr M.D.	1215 Madison Ave	7 March 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/9/49	Arbutus Mem. Park.	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 - 1949	Huntington Williams, M.D.	Mrs. Emma H. Holland	1019 Hill Ave

VS 150

108

contact age is especially important. Physician please write the cause of death clearly and legibly.

G72211 G72211

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 7 5 7

BIRTH NO. B.C.H-80017

1. NAME OF DECEASED (Type or Print): Mary Ida Caroline

2. DATE OF DEATH: 3-7-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 938 Leadenhall St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 938 Leadenhall St

c. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 938 Leadenhall St

5. SEX: Female
6. COLOR OR RACE: Colored.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 6-1-47
9. AGE (In years last birthday): 1 — If Under 1 Year: Months 9, Days 6 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Bally.
12. CITIZEN OF WHAT COUNTRY? Ger.

13. FATHER'S NAME: Flander Caroline
14. MOTHER'S MAIDEN NAME: Louise Singletary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Flander Caroline — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Hydrocephalus

DUE TO

(B) Unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Ulcer about face & body

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-7-, 1949 *to* 3-7-, 1949 *that I last saw the deceased alive on* 3-7-, 1949 *and that death occurred at* 4 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: James C. Dafoe M.D.
23B. ADDRESS: 1016 E. Chase St
23C. DATE SIGNED: 9-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-9-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: James A Hayes — ADDRESS: 142 W. Fitch St

VS 150

157a

G72-12

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72-12

BIRTH NO. 42 Registered No.

1. NAME OF DECEASED (Type or Print): MARY ELIZABETH BOBB

2. DATE OF DEATH: Mar. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1800 E. 32nd. Street
c. Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1800 E. 32nd. Street 9-16

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F	W	Married	Oct. 2, 1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Henry Wahl
14. MOTHER'S MAIDEN NAME: Elizabeth Greb
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mr. John Bobb - 1800 E. 32nd. St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage (Cause)	10 hr.
DUE TO (B)	Hypertension Cardio	4 yrs.
DUE TO (C)	Renal disease	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	Arterio. Sclerosis	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 1945 *to* March 5, 1949 *that I last saw the deceased alive on* March 5, 1949, *and that death occurred at* 11:45 *a. m., from the causes and on the date stated above.*

23A. SIGNATURE: C. W. Meyer M. D.
23B. ADDRESS: 1500 E. 32nd St.
23C. DATE SIGNED: Mar. 7/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/9/49	Loudon Park	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: MAR 8 - 1949
REGISTRAR'S SIGNATURE: Thomas for Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS:

VS 150

BALTIMORE - 13, MARYLAND 131a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72213 — BALTIMORE CITY HEALTH DEPARTMENT — 416 — G72213

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Mattie Callahan
2. DATE OF DEATH: 3-7-49
3. PLACE OF DEATH: A. Baltimore City, Maryland — 900 Madison Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore; D. STREET ADDRESS (If rural, give location) 900 Madison Avenue 11 04
5. SEX: F
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: ? ? 1891
9. AGE (In years last birthday): 58 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Mattie Talbott
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO
17. INFORMANT: Susie McCalpen — ADDRESS: 900 Madison Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia - Cerebral accident

DUE TO

(B) Chronic Nephritis

DUE TO

(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-21-, 1949 *to* 3-6-, 1949 *that I last saw the deceased alive on* 3-6-, 1949 *and that death occurred at* 12 P' m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. D. | 23B. ADDRESS: 600 N. Arlington Ave. | 23C. DATE SIGNED: 3-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 3/11/49 | 24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary | 24D. LOCATION (City, town, or county) (State): Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 8 - 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: A. Halstead - 918 - Druid Hill Ave. 1310 | ADDRESS

VS 150

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Exact age is especially important.

G72214

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72214

1. NAME OF DECEASED (Type or Print): Lee G. Cameron

2. DATE OF DEATH: March 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1322 W. Lafayette Street / 6 0 2

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	married	? ? 1869	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? Cameron
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO:
17. INFORMANT: Walter Cameron - 1144 Cypress Co. Levy Village Road, ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Royer, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/9/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): West Port. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 8 - 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Metropolitan Funeral Home Inc.
ADDRESS: 937 N. Mount St.

VS 151

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72215 G72215

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 4200

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH BELLE SIEGEL
2. DATE OF DEATH: March 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 2520 Oakley Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 55 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2520 Oakley Ave 2-17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Married	1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife		Russia	

13. FATHER'S NAME: Isaac ?
14. MOTHER'S MAIDEN NAME: Rosa Feinberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Henry Siegel	2136 Mt Royal Terrace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 minute
DUE TO
(B) Arteriosclerotic Heart Dis.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 1, 1948 *to* Mar 7, 1949, *that I last saw the deceased alive on* Mar 7, 1949, *and that death occurred at* 9:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Samuel V Tongeker M. D.	36 Park Heights Ave	Mar 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 9, 1949	Hebrew Rosedale Cem	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 - 1949	Huntington Williams, M.D.	Sol Levinson & Bros	1126 W North Ave

VS 150

937

Please write the cause of death clearly and correct age is especially important. Physician:

G72216

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4341

Registered No. G72216

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LILLIAN KEHNE

2. DATE OF DEATH March 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Church Home Hospital

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 4150 Eierman Avenue 27-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white		11/3/1901	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	USA

13. FATHER'S NAME
Edward L. Gissel

14. MOTHER'S MAIDEN NAME
Bertha M. Trexler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		William Kehne	4150 Eirman Ave. Balto,

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute congestive heart failure	
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from* (Autopsy, Inspection or Inquiry) *the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Paul Reyer M.D		March 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/10/49	Baltimore Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 - 1949	Huntington Williams, M.D.	Lilly & Zeiler, Inc.	103 S. Wolfe St.

VS 151

92E Balto. Md.

G72217 ✓ 4x1 G72217

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH CLEM DOGED

2. DATE OF DEATH: 3-5-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 600 S. Potomac St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE

c. Length of stay in Baltimore: LIFE (Yrs. Mon. Days)

D. STREET ADDRESS (If rural, give location): 600 S. Potomac St. 1-0-2

5. SEX: MALE | 6. COLOR or RACE: WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 3-30-1903 | 9. AGE (In years last birthday): 45 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Prop.

10B. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas C. Doged

14. MOTHER'S MAIDEN NAME: Lena Kraus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Catherine Duval ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			Interval between onset and death
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Chronic Myocarditis	1-15-47
ANTECEDENT CAUSES	DUE TO	Arteriosclerotic C.V. Disease.	1-15-47
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	Myocardial Failure.	3-2-49
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	(C)	None.	

19A. DATE OF OPERATION: None | 19B. MAJOR FINDINGS OF OPERATION: None | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.): | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): None h. m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-15-47 19 *to* 3-5-49 19 *, that I last saw the deceased alive on* 3-5 *,* 1949 *and that death occurred at* 6 45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D. | 23B. ADDRESS: 842 West Lee | 23C. DATE SIGNED: 3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 3/9/49 | 24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart | 24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 8 - 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Tilly & Zeiler Inc. ADDRESS: 403 S Wolfe St

VS 150

937

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 3-18-49

G72218 ✓ 154 G72218

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): EDWARD BRETTHOLL
2. DATE OF DEATH: 3/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3214 FOSTER AVE.
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D STREET ADDRESS (If rural, give location): 3214 FOSTER AVE. 26 11

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: (1/24/1873) 1871
AGE (In years last birthday): (76) 77
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?
10B. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM BRETTHOLL
14. MOTHER'S MAIDEN NAME: ~~LORRETTA~~ UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT: LORRETTA BROWN ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Rectum — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 1948 *to* Mar 7, 1949 *that I last saw the deceased alive on* Mar. 6, 1949, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Fawley M. D.
23B ADDRESS: 441 N. Edwood Ave
23C DATE SIGNED: 3/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 3/10/49
24C NAME OF CEMETERY OR CREMATORY: SACRED HEART
24D. LOCATION (City, town, or county) (State): BALTIMORE

DATE RECEIVED BY LOCAL REGISTRAR: MAR 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: Tilly & Zeiler Inc. ADDRESS: 405 S. Wolfe

VS 150

467

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Sheet age is especially important.

72219

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 72219

1. NAME OF DECEASED (Type or Print): Lucy Speake

2. DATE OF DEATH: March 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 632 Pitcher Street, Balto. 17, Md.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 632 Pitcher Street — Zone 17

14-92

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	Negro	Widowed	Oct. 25, 1876	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	-	Port Abacca Chas.Co., Md.	U.S.

13. FATHER'S NAME: Frank Blair

14. MOTHER'S MAIDEN NAME: Sarah Blair

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Mary Moulden	632 Pitcher Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Hemorrhage	One month
DUE TO	(B) trauma	30 days
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) senile	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 1 *1949 to* March 5 *1949 that I last saw the deceased alive on* Monday *1949, and that death occurred at* 8:20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. L. Stewart M.D.	632 W Lanvale St	March 8, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/9/49	Mt. Auburn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 - 1949		Charles R Lane	802 Madison Ave.

VS 150

121a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

BIRTH NO. 72220

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

42 H 1 Registered No. 72220

1. NAME OF DECEASED (Type or Print): Daniel Jones

2. DATE OF DEATH: Mar 5- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1228 N. Spring St

c. Length of stay in Baltimore: 50 yrs (Yrs. / Mon. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1228 N. Spring St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Col	Married	10-3-1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
Unknown		Charlotte Jones 1228 N Spring St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Pulmonary Oedema	2 days
	DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST	(B)	Aortic Insufficiency. [redacted]	unknown
	DUE TO		
	(C)	Arteriolar Sclerosis	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		Senile Bronchial Congestion and Infected Rhinitis.	several days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 3, 1949, *to* March 5, 1949, *that I last saw the deceased alive on* March 4, 1949, *and that death occurred at* 7 30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ralph J. Young M. D.	1429 E Monument St	3/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/9/49	Ashley Ever Green	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
MAR 8 - 1949	Huntington Williams, M.D.	Payner Sanders 1412 E. Preston St

VS 150

92a

Correct age is especially important. Physician: please write the cause of death clearly and fully.

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72222

1. NAME OF DECEASED (Type or Print): August H. Groh

2. DATE OF DEATH: 3/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes
c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 149 S. Morley St 2007

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	widowed	9/25/1869 W	79	/	/

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Germany	USA

13. FATHER'S NAME: John Groh
14. MOTHER'S MAIDEN NAME: Williamowa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Helen C.	149 S. Morley St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pulmonary Edema, bilateral	"
DUE TO (B)	Mania Retardata, left lung	"
DUE TO (C)	Arteriosclerotic cardiovascular disease	"
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Arteriosclerotic gangrene rt. foot	"

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 3/4, 1949 to 3/5, 1949, *that I last saw the deceased alive on* 3/5, 1949 *and that death occurred at* 12:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R Ramsey M. D	St. Agnes Hospital	3/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/8/1949	Loudon Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 8 1949	[illegible] for Registrar, Md	J. B. Rupert & Son	1900 Eutaw Pl

VS 150

937

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72[illegible]

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Petzold

2. DATE OF DEATH: March 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk D. STREET ADDRESS (If rural, give location): 1923 Crafton Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harford Nursing Home, 4700 Harford Rd.

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: F. | 6. COLOR OR RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W. | 8. DATE OF BIRTH: Aug. 11, 1860 | 9. AGE (In years last birthday): 88 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore County, Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs Eugene Booth | ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

DUE TO

(B) Arteriosclerotic Cardio Vascular Disease — 2 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION: — | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from 1-March 19 49 to 7-March 19 49 that I last saw the deceased alive on 7 Mar 19 49 and that death occurred at 4 P m., from the causes and on the date stated above.

23A. SIGNATURE: Chas B. Edwards M. D. | 23B. ADDRESS: 7746 The Alameda | 23C. DATE SIGNED: 8 Mar 49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: March 9 1949 | 24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel | 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 8 - 1949 | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR: Roland L. Fisher | ADDRESS: 7112 Dundalk Ave.

VS 150

93D

G72223 — BALTIMORE CITY HEALTH DEPARTMENT — G72223

CERTIFICATE OF DEATH

Registered No. 08511 1953.7

BIRTH NO.

1. NAME OF DECEASED (Type or Print): addie May Morris

2. DATE OF DEATH: 3-7-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Wicomico
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rosewood State Training School
D. STREET ADDRESS (If rural, give location): (Rural)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	S		25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
		Md	USA

13. FATHER'S NAME: Jerome Morris

14. MOTHER'S MAIDEN NAME: addie adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia - probable
DUE TO atelectasis
(B) measles
DUE TO
(C) Penicillin reaction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-2-1949 *to* 3-7-1949 *that I last saw the deceased alive on* 3-7-1949 *and that death occurred at* 4.15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. L. Lasser M. D.	University Hosp Balto	3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/10/49	Parsons	Salisbury, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 9 - 1949		John C. Mullen Jr.	2415 E. Monument St

VS 150

35

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G72224 ✓ G72224

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 201 Registered No.

1. NAME OF DECEASED (Type or Print): FREDERICK S ILL

2. DATE OF DEATH: 3/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEST BALTO. GEN HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2727 Hudson St 26-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Widowed	7-2-1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook	Mary Co.	Balto. Md.	

13. FATHER'S NAME: Albert Ill
14. MOTHER'S MAIDEN NAME: Emma Zeigert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	215-10-8008	Rosalie Ill	2727 Hudson St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio-respiratory arrest
DUE TO
(B) Hodgkin's Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/1/49 *to* 3/7/49 *that I last saw the deceased alive on* 3/7/49 *and that death occurred at* 0:55 PM *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 6 E. Lex.
23C. DATE SIGNED: 3/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-10-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Olive Cem
24D. LOCATION (City, town, or county, State): Randallstown Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 9 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: John C. Milly Inc
ADDRESS: 2435 E Oliver St

VS 150

44 B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72225

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John J. Conroy

2. DATE OF DEATH: March 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1711 N. Regester St. 8 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Feb. 2, 1883	66	1	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		Baltimore	

13. FATHER'S NAME: John F. Conroy

14. MOTHER'S MAIDEN NAME: Annie Massey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Margaret M. Conroy	1711 Regester St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) arteriosclerosis — 4 yrs

DUE TO

(C) Hypertension — 5 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__ *to* Mar 6, 19 49 *that I last saw the deceased alive on* Mar 6, 19 49 *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. H. Blumer M. D.	2736 Baylor Rd	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/10/49	Cathedral	Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 9 - 1949	[illegible]	Clarence F. Hoffmann	1639 Broadway

VS 150

94a

Correct age is especially important. Physician please write the cause of death clearly and legibly.

G72226 G72226

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 4201

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GUSTAVE L. DEICH

2. DATE OF DEATH: March 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1206 Carroll Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	single	Feb. 25, 1907	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): machinist

10B. KIND OF BUSINESS OR INDUSTRY: Cat's Paw Rubber Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis Deich

14. MOTHER'S MAIDEN NAME: Anna Volkman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Anna Volkman DEICH ADDRESS: 1206 Carroll St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease

(B) Coronary artery disease
Acute Congestive Heart failure

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: W. J. McCafferty M.D.

23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: March 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	MARCH 10 '49	ST PAUL CEM	VIOLETVILLE, M

DATE RECEIVED BY LOCAL REGISTRAR: MAR 9 - 1949

REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR: Harry H Metzger ADDRESS: 440 Edmondson Ave

931

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information above should be entered legibly. Correct age is especially important. Physician: please write the cause of death clearly and fully.

172.27.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 pp 1 (172.27) Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edith M Cropsey

2. DATE OF DEATH: 3-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2604 Riggs Ave # 16 16

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 1 Day: Hours / Min.
Fem.	W	MARRIED	FEB. 28, 1895	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Pa.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? HECKER	?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mr. John F Cropsey (Husband)	2604 Riggs Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis; acute
DUE TO
(B) & acute pulmonary edema
Diabetes mellitus
DUE TO
(C) & arteriosclerotic CVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-7-1949 *to* 3-7-1949 *that I last saw the deceased alive on* 3-7-1949 *and that death occurred at* 6:40 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John H. Rosser M.D.	University Hosp. Balto	3-7-49

24A. BURIAL, CREMATION, REMOVAL	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	MARCH 11 1949	NEW CATHEDRAL	910 FREDERICK RD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 9 - 1949	[illegible]	Harry A Wiltze	4101 Edmondson Ave

61

Dr. Dunnigan

G72428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Dr. 1

G72428

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BERNARD B. LOCHTE, SR.

2. DATE OF DEATH Mar. 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5307 Purlington Way

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5307 Purlington Way

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	June 25, 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Supervisor	Esskay Co.	Baltimore, Maryland	

13. FATHER'S NAME: Frank J. Lochte

14. MOTHER'S MAIDEN NAME: Mary Caughy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
	213-03-9219	Mrs. Barbara Lochte, 5307 Purlington Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary thrombosis	15 min.
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) generalized arteriosclerosis	uncertain
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Parkinson's Disease	uncertain

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	none	none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec., 1940, *to* 3/5, 1949, *that I last saw the deceased alive on* 3/5, 1949, *and that death occurred at* 3.50 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William J. Dunnigan M. D.	31 E. North Ave	3-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-9-49	Holy Redeemer	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 9 - 1949	Martin for Williams, M	Leonard J. Ruck, 5305 Harford Road.

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Information obtained by inquiry may be supplied by informant. Physician: please write the cause of death clearly and correct age is especially important.

G72229 420.0 ✓ X G72229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

561 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles J Thomas

2 DATE OF DEATH: Mar 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland B COUNTY: Howard
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sykesville
D STREET ADDRESS (If rural, give location): Rural

5. SEX	6. COLOR OR RACE	7 SINGLE MARRIED WIDOWED DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	Sept 15, 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Laborer	—	Maryland	US

13. FATHER'S NAME: John L Thomas

14 MOTHER'S MAIDEN NAME: Rebecca Hatfield

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		212-16-5180	self	above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease - Enlarged heart - auric fibrillation - Congestive failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cirrhosis of Liver - Bleeding Esophageal Varices - Internal Hemorrhage

DUE TO

(C) General Cachexia & Malnutrition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Retroperitoneal hernia - intestinal obstruction

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Post operative

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
2/16/49 2/27/49	Internal hernia - intestinal obstruction	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from 2/13, 1949 to 3/8, 1949, that I last saw the deceased alive on 3/8, 1949, and that death occurred at 3:40 A m., from the causes and on the date stated above.

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
D. M. Hunter M.D.	Church Home	Mar 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/10/49	Springfield	Sykesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 9 1949		Harry Warr	Sykesville, Md.

VS 150

124a

G72250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54

G72250

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rose Leah Denny

2. DATE OF DEATH: March 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3705 Old York Road

c. Length of stay in Baltimore: Yrs. 9 Mos. 0 Days 1

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3705 Old York Road

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 30, 1898
9. AGE (In years last birthday): 50 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert R. Compton
14. MOTHER'S MAIDEN NAME: Julia Zamiosld

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr George P. Denny, ADDRESS: 3705 Old York Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cachexia	2 wks.
DUE TO (B)	Carcinoma of rectum	1 yr.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION: Aug. 11, 1948
19B. MAJOR FINDINGS OF OPERATION: Intestinal obstruction
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 12, 1948, *to* Mar. 6, 1949, *that I last saw the deceased alive on* Mar. 3, 1949, *and that death occurred at* 1:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edward W. Richardson Jr. M. D.
23B. ADDRESS: 9 East Chase St.
23C. DATE SIGNED: 3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/9/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 9 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: William Cook, Inc., ADDRESS: 1217 St. Paul St.

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Funeral Director Indiana, Pa.

46D

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

BIRTH NO. 972-31

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 976.0 G72-31 Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE HAASE N 800.4

2. DATE OF DEATH: March 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 705 Appleton Street 1604

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	Nov 17th 1876	72	3 / 21	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Railway Mail Clerk	U. S. Govt	Balto. Md.	U. S. A.

13. FATHER'S NAME: Robert Haase

14. MOTHER'S MAIDEN NAME: Louisa Rausch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT
Yes	Spanish-American		Louis Robt. Haase 200 E. ~~Long~~ Ave DuBois Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bullet wound of brain
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	750 Appleton Street

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21F. HOW DID INJURY OCCUR?
March 8, 1949 7:55 Am.		Firearms

22. *I certify that I took charge of the remains described above, held an* Ins. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
[signature] M.D.		3-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/11/49	Woodlawn	Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 9 - 1949	[signature]	Wm Cook Inc.	217 St. Paul st.

VS 151

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67212

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 610

67212

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Henry Brown

2. DATE OF DEATH: March 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
2054 E Federal Street Balto Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Maryland

c. Length of stay in Baltimore: Life — Yrs. / Mos. / Days

D. STREET ADDRESS (If rural, give location): 2054 E Federal Street 8 26

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	March 3, 1867	82	0 / 5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Brewery Work	Balto Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown Germany	Margaret Brown Germany

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	No	None	Mrs Ella May Brown (Wife)	2054 E Federal St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Arteriosclerotic Myodegeneration of Heart. MYOCARDIAL DEGENERATION

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Prostate Hypertrophy with urinary retention. PROSTATE HYPERTROPHY URINARY INFECTION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 1948 *to* March 7th, 1949, *that I last saw the deceased alive on* March 7 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
K. Thompson M. D.	1623 E. N. Avenue	3/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 11, 1949	Parkwood Cemetery	Taylor Ave Balto 14 Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 9 - 1949	[illegible] Williams	Albert L Nolte Jr	1606 N Chester St

VS 150

937

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 4 r° 1

BIRTH NO. 1643

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print)	Herbert J. Schaefer
2. DATE OF DEATH	March 6, 1949
3. PLACE OF DEATH: A.	Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	3008 Presstman St.
C. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	3008 Presstman St. 16 07
5. SEX	M
6. COLOR OR RACE	W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	Married
8. DATE OF BIRTH	Dec. 28 1897
9. AGE (In years last birthday)	51
If Under 1 Year: Months / Days / Hours / Min.	2 / 6
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Radio man
10B. KIND OF BUSINESS OR INDUSTRY	Radio Shop
11. BIRTHPLACE (State or foreign country)	Hickville N.Y.
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	? Schaefer
14. MOTHER'S MAIDEN NAME	Theresa Lindenman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	Yes
(If yes, give war or dates of service)	1st W.W.
16. SOCIAL SECURITY NO.	
17. INFORMANT	Esther L. Schafer
ADDRESS	3008 Presstman St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute congestive cardiac failure.	
ANTECEDENT CAUSES	due to Hypertrophy and dilatation of heart.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	due to Coronary arteriosclerosis.	
	due to Chronic adhesive pericarditis.	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐
21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	George G. Merrill M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED	3/7/49	
24A. BURIAL, CREMATION, REMOVAL (Specify)	Burial	
24B. DATE	March 9/49	
24C. NAME OF CEMETERY OR CREMATORY	Balt. National Cemetery	
24D. LOCATION (City, town, or county) (State)	5501 Frederick Rd.	
DATE RECEIVED BY LOCAL REGISTRAR	MAR 9 - 1949	
REGISTRAR'S SIGNATURE		
25. FUNERAL DIRECTOR	Frank Della Rose	
ADDRESS	322 S. High St.	

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95c

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 no 1 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): A. HARRIS GOODWIN

2. DATE OF DEATH: Mar. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 134 S. Morley Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 134 S. Morley St. 20 07

5. SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If under 1 Year: Months. Days	If under 24 hours: Hours. Min.
male	white	widowed	June 20, 1874	74 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
foreman	Loudon Park Cem.	Balto. Co., Md.	

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Unknown	-

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
no	217-01-4140	Mrs. Weatherstine	134 S. Morley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary artery thrombosis — 4 days

DUE TO

(C) Generalized arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 6, 1949, *to* March 7, 1949, *that I last saw the deceased alive on* March 6, 1949, *and that death occurred at* 12.45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C. DATE SIGNED
Leonard Yaffe M. D.	3101 W Baltimore St.	3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/10/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 9 - 1949	Thelma Fox Williams, M.D.	Wm. J. Tickner & Sons	Balto., Md.

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as correct as possible. Physician please write the cause of death clearly and legibly. Special attention is especially important.

G72235 ✓ — X G72235

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 Registered No.

1. NAME OF DECEASED (Type or Print): HELEN HANWAY MATTHEWS

2. DATE OF DEATH: 3/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — St. Agnes
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Yrs. — Mos. — Days —

4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Reisterstown
D. STREET ADDRESS (If rural, give location): Mt. Gilead Farm Owenstown

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 11-26-1887
9. AGE (In years last birthday): 61 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Winfield Scott Hanway
14. MOTHER'S MAIDEN NAME: Margaret Ella Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT — ADDRESS: Mr. Claude V. Matthews — Mt. Gilead Farm Reisterstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Metastatic Carcinoma to Sup. mediastinum, lungs + pleura — INTERVAL BETWEEN ONSET AND DEATH: 4-6 mos
DUE TO
(B) Carcinoma of breast — 6 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/2, 1949 *to* 3/5, 1949 *that I last saw the deceased alive on* 3/8, 1949 *and that death occurred at* 3:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Sidney Johnson Venable M. D.
23B. ADDRESS: St. Agnes Hospital.
23C. DATE SIGNED: 3/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/11/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 9 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR — ADDRESS: WM. J. TICKNER & SONS Balto., Md.

VS 150

50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as correct as is especially important. Physician: please write the cause of death clearly and legibly.

G72636 G72636

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 153 Registered No.

1. NAME OF DECEASED (Type or Print): Doris Caplan
2. DATE OF DEATH: March 8, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
c. Length of stay in Baltimore: Life Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 4917 Greenspring Ave
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 1-2-07
9. AGE (In years last birthday): 42 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Abraham Blumenthal
14. MOTHER'S MAIDEN NAME: Bessie Caplan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Carcinoma of large Bowel 9 mos.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Oct. '48 (Crawford)
19B. MAJOR FINDINGS OF OPERATION: Presumably Carcinoma of large Bowel
20. AUTOPSY? YES [X] NO [ ]
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/2, 1949 to 3/8, 1949 that I last saw the deceased alive on 3/8, 1949, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

23A. SIGNATURE: David C. Salisbury M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 3-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-9-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: 3/10/49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jos. L. Lewis Inc. ADDRESS 2100 Eutaw Pl

VS 150

46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and forcibly.

G72537

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72537

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES HIBOWITZ
2. DATE OF DEATH: 3-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3707 Spaulding Ave
C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3707 Spaulding Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	married		77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Russia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Not Known	Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Sarah Rebowitz	3707 Spaulding Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	Unknown
DUE TO	Cardio vascular renal disease	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Heart failure + Hypertension	4 or 5 yr
DUE TO	Asthma	
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 0 to Mar 6 *to* Mar 7, 1949 *that I last saw the deceased alive on* Mar 7, 1949 *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert H. Kahan M.D.	3700 Park Heights Ave	Mar 8 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-9-49	Hebrew Mt Carmel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR - 7 1949	[illegible] Washington for Hutzler, Inc.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician please write the cause of death clearly and legibly.

121a

BIRTH NO. 772[illegible]38

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 672[illegible]38

1. NAME OF DECEASED (Type or Print): M. Albert Louis Thomas Sr.

2. DATE OF DEATH: 3/8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — w mtl.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: 6 2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural Elkridge
D. STREET ADDRESS (If rural, give location): 1918 St. Augustine ave. Elkridge

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 1 Day: Hours / Min.
M	Wh.	married	Nov. 17, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?	retired	Baltimore, Maryland	U.S.

13. FATHER'S NAME: Holmes Thomas

14. MOTHER'S MAIDEN NAME: Eda Beingier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Dorothy L. Howe	(same as above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Coronary Arteriosclerosis

DUE TO

(C) Congestive Heart Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-6, 1949, *to* 3-8, 1949 *that I last saw the deceased alive on* 3-8, 1949, *and that death occurred at* 12:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James McC. Finney M. D.	Union Memorial Hospital	3-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	3/10/49	St. John	Long Green

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
3/9/49	Huntington Williams, M.D.	C. E. Arthur	Fork Md.

VS 150

95 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

G72-59

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. E 9740 G72-59 991

BIRTH NO. B.C.-48-18891

1. NAME OF DECEASED (Type or Print): JAMES CALVIN GARDNER, JR.

2. DATE OF DEATH: March 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1425 Race Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1425 Race Street 2 3 c/

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Infant	Aug. 29, 1948		6	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant		Baltimore, Maryland	USA

13. FATHER'S NAME: James Calvin Gardner, Sr.

14. MOTHER'S MAIDEN NAME: Emma Luedtke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no			James Calvin Gardner, Sr.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Suffocation
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1425 Race Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): March 6, 1949 (?) ? m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Probable overlay of parents 2 : 1

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: M. J. McCafferty, M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Mar. 9 1949
24C. NAME OF CEMETERY OR CREMATORY: Bedon Hill Cem.
24D. LOCATION (City, town, or county) (State): Ann Arundel Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: 3/9/49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Howard Evans
ADDRESS: 1400 E. Baltimore St. Baltimore 39, Md.

VS 161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1820

G72250

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1949 G72250

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ethel Turner Bailey

2. DATE OF DEATH: 7 March 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1504 Franklin St

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto

c. Length of stay in Baltimore: 20 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1504 Franklin St

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F	C		Aug 1906	42	6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
A. W.	—	Phila. Pa	U.S.A.

13. FATHER'S NAME: Eugene TURNER

14. MOTHER'S MAIDEN NAME: AGNES TURNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	Husband	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia

DUE TO

(B) Cellulitis, Right Leg; ± Septicemia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 3 March, 1949, *to* 7 March, 1949, *that I last saw the deceased alive on* 6 March, 1949, *and that death occurred at* 5:45 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
B. M. Woodward, M.D.	1215 Mad. ave	8 March

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-10-49	Arbutus Memorial Park	Arbutus Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 9 - 1949		Elroy O. Wilson	1000 Brantly Ave

VS 150

108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physician please write the cause of death clearly and legibly.

G72241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

151 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Samuel W. Polek

2. DATE OF DEATH: March 3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 917 S. Benney St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
917 S. Benney St.
C. CITY OR TOWN (If outside corporate limits, write RFD and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
917 S. Benney St — 1 - 4

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 3 1886
9. AGE (In years last birthday): 63
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Box Factory
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Mathew Polek
14. MOTHER'S MAIDEN NAME: Klymek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215070718
17. INFORMANT: Mrs Wojciechowska
ADDRESS: 917 S. Benney St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)
A. Carcinoma of Stomach — Interval between onset and death: 1yr.
DUE TO
B.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
Arteriosclerotic Heart Disease with Heart Block

19A. DATE OF OPERATION: May 1948
19B. MAJOR FINDINGS OF OPERATION: malignancy of stomach.
20. AUTOPSY? YES / NO ✓

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give street and number)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* Mar 5, 1949 *to* Mar 8, 1949 *that I last saw the deceased alive on* Mar 7, 1949 *and that death occurred at* 3A. m. *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. D. Lyday, M. D.
23B. ADDRESS: 432 N. Patterson Park Ave
23C. DATE SIGNED: 3-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Mch. 10 49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, State or Foreign Country): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: MAR 9 - 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Fred W. Ozagenski
ADDRESS: 1930 Eastern Ave

VS 150

46 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72,442 ✓ X G72,442

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No. 161

1. NAME OF DECEASED (Type or Print): ROBERT MICHAEL KYLE
2. DATE OF DEATH: March 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: 245 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: NY
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write R(URAL) and give township): New York
D. STREET ADDRESS (If rural, give location): 128 Sherman Ave.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: 4/21/87
9. AGE (In years last birthday): 61 (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dining room steward
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): NYC
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Robert James Kyle
14. MOTHER'S MAIDEN NAME: Mary E. Kelly
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Records- US Marine Hospital, Balto, Md. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the larynx with generalized metastasis — Duration Unknown
DUE TO
(B) Bronchopneumonia — Duration Unknown
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.):
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 2, 1948 *to* Mar. 4, 1949 *that I last saw the deceased alive on* Mar. 4 1949 *and that death occurred at* 5:20A *m., from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson / John L. Wilson M.D.
23B ADDRESS: US Marine Hospital, Balto, Md.
23C DATE SIGNED: 3/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B DATE: 3-9-49
24C NAME OF CEMETERY OR CREMATORY: H. Setters
24D LOCATION (City, town or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR
REGISTRAR'S SIGNATURE:
25 FUNERAL DIRECTOR: Earl B. Robertson ADDRESS:

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physician: please write the cause of death clearly and legibly.

47a

G72483 ✓ E970 + G72483

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

1. NAME OF DECEASED (Type or Print): Cap't. Harold MOSER N-971.9

2. DATE OF DEATH: 3/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospit l
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4 01
D. STREET ADDRESS (If rural, give location): 118 N. Charles St. U.S. Army

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W	MARRIED	11/4/1899	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier
10B. KIND OF BUSINESS OR INDUSTRY: Military
11. BIRTHPLACE (State or foreign country): HAMILTON OHIO
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: LOGAN M. MOSER
14. MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO
17. INFORMANT: U.S. Army ADDRESS: H. Geo Meade, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Amytal Poisoning	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Apt. House
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 118 N. Charles St., Third floor
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): March 1, 1949 9:15 P.M.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Ingestion of sleeping pills

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]
23C. DATE SIGNED: 3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/10/49
24C. NAME OF CEMETERY OR CREMATORY: Arlington National
24D. LOCATION (City, town, or county) (State): Alexandria, Va.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Tilly & Zeiler ADDRESS: 403 S. Wolfe St.

VS MAR 9 - 1949

1630

G72244 G72244

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 982.6

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDNA EPPS — N874.7

2. DATE OF DEATH March 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1214 North Wolfe Street 807

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 2, 1913
9. AGE (In years last birthday): 35 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Middlesex County, Virginia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lawrence Epps — ADDRESS: 1214 North Wolfe St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hemorrhage due to stab wound of neck
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 630 Montgomery Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 3 8 49 1 a.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Sharp instrument

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE Earl L. Roya MD per G. G. Merrill MD
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED March 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: March 13, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mount Calvary Cem.
24D. LOCATION (City, town, or county) (State): Anne Arundel Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Mrs. Robert Elliott & Daughter
ADDRESS: 1129 N. Caroline Street

VS 151

167

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72245 ✓ G72245

JL - 127198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

545 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): William Carson

2. DATE OF DEATH: March 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 39 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1116 Lowe St.

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Sep.
8. DATE OF BIRTH: July 4, 1880
9. AGE (In years last birthday): 68 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Will Carson
14. MOTHER'S MAIDEN NAME: Lucinda ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: Balto. C. H. Records, 4940 Eatern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Pyloric obstruction — 2 mos.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ No ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 28, 1949, *to* March 7, 1949 *that I last saw the deceased alive on* March 7, 1949, *and that death occurred at* 12.30PM *from the causes and on the date stated above.*

23A. SIGNATURE: G. L. Rogers, M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: Mar. 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 10/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): B. C. County Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 9 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Wm. P. H. Ellis Jr.
ADDRESS: 1129 N. Caroline St. 107

VS 150

G72246 ✓ 451 G72246

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. | Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print): Dr. JOSEPH E. GICHNER.

2. DATE OF DEATH: 3/8/1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 3201 Garrison Blvd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 68 Yrs. ___ Mos. ___ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 3201 Garrison Blvd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married.	8/18/1863.	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Physician.		Austria-Hungary	U.S.A.

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Jacob Gichner	Johanna Enoch.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT ADDRESS
?		Dr. Manuel C. Gichner, Topeka, Kansas.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gangrene left foot — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO

(B) Arteriosclerosis, generalized — 15 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. , 19 48 to Mar. 8 , 19 49 *that I last saw the deceased alive on* Mar. 5 , 19 49 *and that death occurred at* 10.10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
George N. Yeager M. D.	Med. Arts Bldg.	Mar. 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/10/1949.	Baltimore Hebrew	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR ADDRESS
MAR 9 - 1949	[illegible] Baltimore, Md.	David Lanahan & Son. 1902 Eutaw Place.

VS 4-50

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4200 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EMMA R. ALT

2. DATE OF DEATH: 3-7-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1747 Wilkens Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1747 WILKENS AVE 19 04

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: JAN. 16-1874
9. AGE (In years last birthday): 75 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHARWOMAN
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ? SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 212-03-2833A
17. INFORMANT: MR. WALTER R. ALT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteria sclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(B) Hypertension — 1 yr
DUE TO
(C) None

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 1/2, 1949 *to* 3/7, 1949 *that I last saw the deceased alive on* 3/7, 1949 *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Benjamin Miller M. D.
23B. ADDRESS: 2020 Wilkens Ave
23C. DATE SIGNED: 3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 3-11-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon PARK
24D. LOCATION (City, town, or county) (State): Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: MAR 9 - 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Thos. J. Kenealy Inc. ADDRESS: 1600 Hollins St

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72248 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type or correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): (Evie) EVA MITCHELL

2. DATE OF DEATH: March 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1515 Baker Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1515 Baker Street 15-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	Colored	Widow	Jan. 10- 1888.	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lawrence, S. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Washington.
14. MOTHER'S MAIDEN NAME: Ellen Adams.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bessie Mitchell ADDRESS: 766 W. Saratoga St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial degeneration
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Royer M.D.
23B CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 3-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Shipped
24B. DATE: Mar 11, 1949
24C. NAME OF CEMETERY OR CREMATORY: Clinton
24D. LOCATION (City, town, or county) (State): South Carolina

DATE RECEIVED BY REGISTRAR: MAR 9 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams ADDRESS: 322 Schroeder St

VS 151

93D

G72249

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 1200 Registered No. G72249

1. NAME OF DECEASED (Type or Print): ALBERT PEARSON

2. DATE OF DEATH: 3/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2034 E. NORTH AVE

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: AUG 27 1877
9. AGE (In years last birthday): 72 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): CAMBRIDGE MD.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOSEPH PEARSON
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Pearson ADDRESS: 2034 E. North Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage accident
DUE TO
(B) Hypertension C V D
DUE TO
(C) Arteriosclerotic Heart Disease enlarged heart
DUE TO
Gen Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from 3/4 1949 to 3/8 1949 that I last saw the deceased alive on 3/8 1949 and that death occurred at 4 P.M., from the causes and on the date stated above.

23A. SIGNATURE: Donald W Murray M.D.
23B. ADDRESS: Church Home
23C. DATE SIGNED: 3/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Mar 12th 1949
24C. NAME OF CEMETERY OR CREMATORY: Morelands
24D. LOCATION (City, town, or county) (State): Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR: MAR 9 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Lee G. Leach ADDRESS: 1203 E. Pattenson Park Ave

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72250

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72250

BIRTH NO. | Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Mabel M. HAMILTON
2. DATE OF DEATH: 3-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTIMORE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2515 E. Biddle, ST.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2515 E. Biddle ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	MARRIED	MARCH 19, 1892	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home's Wife		KANSAS	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DANIEL HARDING	MELISSA A. JARRETT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		WALTER S. J. HAMILTON	2515 E. Biddle

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Syphilis Central Nervous System — INTERVAL BETWEEN ONSET AND DEATH: 28 yrs.
DUE TO
(B)
DUE TO
(C) Locomotor Ataxia — 20 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 1939 *to* March 7 1949 *that I last saw the deceased alive on* March 7 1949 *and that death occurred at* 11:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Silverstein M. D.	1101 N. Milton Ave	3-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	3-11-49	PARKWOOD	BALTIMORE Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 9-1949		John A. Moran	3000 E. Balto. St.

VS 150

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G72251 BALTIMORE CITY HEALTH DEPARTMENT Reg. No. G72251

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Mrs. Florence H. Zuell
2. DATE OF DEATH: March 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: 41 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 76 08
D. STREET ADDRESS (If rural, give location): 3429 E. Baltimore St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Married	9/7/07	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: John B Behr
14. MOTHER'S MAIDEN NAME: Louisa Pumphrey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Adam H. Zuell ADDRESS: 3429 E Baltimore St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(B) Hypertensive Arterio-sclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 8, 1949 *to* March 8, 1949 *that I last saw the deceased alive on* March 8, 1949, *and that death occurred at* 9:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ray E. Parsons, Jr. M.D.
23B. ADDRESS: St. Joseph's Hosp
23C. DATE SIGNED: March 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 12 1949
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cem
24D. LOCATION (City, town, or county) (State): Eastern Ave Road

DATE RECEIVED BY LOCAL REGISTRAR: MAR 9 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: John C. Moran ADDRESS: 3000 E Baltimore St

VS 150

937

G72252 ✓ 4rr ✓ A72252 3/1079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles H. Thornton

2. DATE OF DEATH: Monday March 7 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 140 W. Clement St.
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (Zone 30)
D. STREET ADDRESS (If rural, give location): 140 W. Clement St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	December 28 1875	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Steward Captain	Fish Packing Meat Packers	Balto. Md	U.S.A.

13. FATHER'S NAME: Albert Franklin Thornton
14. MOTHER'S MAIDEN NAME: Mary (?)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		213-03-1348	Mrs. Marion L. Thornton	(Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency

DUE TO

(B) Myocarditis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

If OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Terminal Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from March 1 1949 to March 7 1949 that I last saw the deceased alive on March 7 1949 and that death occurred at 9:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John G. Schmunk M. D.	1337 S. Charles St	3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Thursday March 10 1949	London Park Cem.	Balto, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 9 - 1949	Huntington Williams, M.D.	C. Howard Evans	1409 W. Lanvale St 90 Baltimore 30 Md.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72253 ✓ X G72253

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4/20

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Leamon L. Forrest
2. DATE OF DEATH: 3/8/'49
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto Labor
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Virginia B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Norfolk
c. Length of stay in Baltimore: Yrs. Mos. Days
D STREET ADDRESS (If rural, give location): Algonjin Park
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 3/12/1899
9. AGE (In years last birthday): 49 — If Under 1 Year: Months II Days 26 — If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief Engineer
10B. KIND OF BUSINESS OR INDUSTRY: Esso Standard Oil
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Standard Oil Co. Files ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl Boyer M.D
23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C DATE SIGNED 3.9.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE 3/11/49
24C. NAME OF CEMETERY OR CREMATORY: Old Bacon Castle
24D LOCATION (City, town, or county) (State): Smithfield, Virginia

DATE RECEIVED BY LOCAL REGISTRAR: MAR 9 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: James T. McCauley ADDRESS: 130 E. Fort ave

VS 151

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72254 G72254 5-43 G72254

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C. 49-02696

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Physician's please write the cause of death clearly and legibly. Special attention is especially important.

1. NAME OF DECEASED (Type or Print): Carol Joan Gordon

2. DATE OF DEATH: 3/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY: Howard / Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellicott City
D. STREET ADDRESS (If rural, give location): 26 Orchard St.

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 2/10/49
9. AGE (In years last birthday): If Under 1 Year: Months / Days: 27 / If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Gordon
14. MOTHER'S MAIDEN NAME: Maude Harden
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital Heart Disease - Interventricular septal Defect. — INTERVAL BETWEEN ONSET AND DEATH: 27 Days
DUE TO
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Intracerebral hemorrhage — 27 Days

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/10 1949 *to* 3/9 1949 *that I last saw the deceased alive on* 3/9 1949 *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sidney Johnson Veatch Jr. M.D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/10/49
24C. NAME OF CEMETERY OR CREMATORY: St. Johns Cem.
24D. LOCATION (City, town, or county) (State): Ellicott City Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 9 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Easton Sons
ADDRESS:

VS 150

157E

G72255 BALTIMORE CITY HEALTH DEPARTMENT 4th G72255

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print): Delia J. Gavan

2. DATE OF DEATH: 3/7/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2210 Roslyn Avenue

C. Length of stay in Baltimore: 67 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2210 Roslyn Avenue 15-44

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Single	-------	About 74	-- --	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	-------	England	

13. FATHER'S NAME: Patrick Gavan

14. MOTHER'S MAIDEN NAME: Mary Leveny

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Anna J. Gavan	2210 Roslyn Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 4 mo

DUE TO

(B) advanced uterine fibroids — about 5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 48 *, 19 , to* 3-7-49 *, 19 , that I last saw the deceased alive on , 19 , and that death occurred at m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter S. Aubert M. D.	[illegible]	3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/9/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 9 - 1949		H. W. Mears and Son	92 D

G72256 — BALTIMORE CITY HEALTH DEPARTMENT — G72256

CERTIFICATE OF DEATH

Registered No. 54

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rebecca Bowman

2. DATE OF DEATH: Mar 9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 439 N. Caroline St

c. Length of stay in Baltimore: 2 Months (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE — B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Philda. Pa.

D. STREET ADDRESS (If rural, give location): 3624 N Haverford Ave

5. SEX: Female

6. COLOR OR RACE: Color

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: Dec 25/1908

9. AGE (In years last birthday) (If under 1 year: Months, Days; If under 24 hours: Hours, Min.): 40

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bonneau S Carolina

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: ℓ

14. MOTHER'S MAIDEN NAME: ℓ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): N (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: H

17. INFORMANT: Frank Bowman — ADDRESS: 3624 Haverford Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA - RECTUM — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Nov. 48

19B. MAJOR FINDINGS OF OPERATION: CARCINOMA - RECTUM (colostomy)

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-20-1949 to 3-9-1949, that I last saw the deceased alive on 3-8-1949, and that death occurred at 11 10 A.M. from the causes and on the date stated above.

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: RAYNER BROWNE, M.D. 1500 EAST MADISON ST. BALTIMORE, MD.

23C. DATE SIGNED: 3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3-12-49

24C. NAME OF CEMETERY OR CREMATORY:

24D. LOCATION (City, Town, or County) (State): Phila., Pa

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949

REGISTRAR'S SIGNATURE: Investigator for Williams, M.D.

25. FUNERAL DIRECTOR: Elroy O. Wilson — ADDRESS: 1000 Bentley Ave

VS 150

46 D

WITH UNFADING INK. Every item of information should be carefully supplied. The... important. Physician please write the cause of death clearly and legibly.

G72257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

584 Registered No. G72257.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Amanda Shaffer

2. DATE OF DEATH: March 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp
c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westminster
D. STREET ADDRESS (If rural, give location): 53 Penn Ave.

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: July 5, 1866
9. AGE (In years last birthday): 82
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK
10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Paralytic ileus
DUE TO
(B) Post operative cholecystostomy
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: March 4, 1949
19B. MAJOR FINDINGS OF OPERATION: Chronic Cholecyst.dis. with cholelithiasis
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 4, 1949 *to* March 8, 1949, *that I last saw the deceased alive on* March 8, 1949, *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Fred A. Fargino M.D.
23B. ADDRESS: Md. Gen. Hosp
23C. DATE SIGNED: March 8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Mar. 14, 1949
24C. NAME OF CEMETERY OR CREMATORY: Krider's Cemetery
24D. LOCATION (City, town, or county) (State): Near Westminster Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. Francis Reese
ADDRESS: Westminster, Md.

VS 150

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G72258

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 G72258 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Augusta Reves

2. DATE OF DEATH: March 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-2
D. STREET ADDRESS (If rural, give location): 4430 Minnesota ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	1-16-70	79	1 / 20	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Christopher Falty
14. MOTHER'S MAIDEN NAME: Mary Weaver.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Myocardial infarction	4 hrs
DUE TO (B)	Hypertensive heart disease	20 yrs.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Acute cholecystitis	

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/7, 1949 *to* 3/8, 1949 *that I last saw the deceased alive on* 3/8, 1949, *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: M Edgerton, M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 3/8/48

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	3/12/49	Parkwood	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949
REGISTRAR'S SIGNATURE: Livingston Williams, M.D.
25 FUNERAL DIRECTOR: Lasseter Funeral Home ADDRESS: 7401 Belair Rd

VS 150

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G72259 G72259

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

150 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CARRIE V. McGAHN

2. DATE OF DEATH: March 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1742 East North Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1742 East North Ave. 8-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	May 24, 1878 (68)	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME: John Blessing

14. MOTHER'S MAIDEN NAME: Mary J. Schaub

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Mr. [illegible] Blessing	1742 East North Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uraemia	2 weeks
DUE TO (B)	Senile dementia	2 months
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Generalized arteriosclerosis	years
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/23/, 1949 *to* 3/7/, 1949 *that I last saw the deceased alive on* 3/7/, 1949, *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Isaac Friedman M. D.	1737 E. North Avenue	3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/10/49	Woodlawn	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 10 1949	Lemington Williams, M.D.	William Cook, Inc.,	1217 St. Paul St.

VS 150

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G72200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72200

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CLIFFORD HENRY SPRAGUE

2. DATE OF DEATH: March 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2225 Eutaw Place
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2225 Eutaw Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Married	Sept. 24, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Horseman	Self	Rochester, N.Y.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Sprague	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No	214-22-8297	Mrs Mary Sprague, 2225 Eutaw Place

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic myocarditis	Long
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Arterio Sclerosis	Long
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1948, 19__, *to* March 8, 1949, 19__, *that I last saw the deceased alive on* 3/8/49, 19__, *and that death occurred at* 6 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1901 Eutaw Place, City	3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/12/49	Stone Chapel	Baltimore County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 10 1949	[signature] Registrar, Baltimore, Md.	William Cook, Inc., 1217 St. Paul St.

VS 150

937

...LY, WITH UNFADING INK. Every item of information should be carefully supplied. The ... important. Physician: please write the cause of death clearly and fully.

G72201 — BALTIMORE CITY HEALTH DEPARTMENT — G72201

CERTIFICATE OF DEATH

E 983.5

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM PENN OFFLEY N-803. — 2. DATE OF DEATH: March , 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1707 N. Bentalou Street 15-3

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	June 23rd 1884	64	8 / 16	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	Eliott Machine Co	Delaware	U. S. A.

13. FATHER'S NAME: Wm P. Offley
14. MOTHER'S MAIDEN NAME: Louisa Schmidt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		212-10-1431	Helen Offley	1707 N. Bentalou St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull
~~(B)~~ Intracranial hemorrhage
Contusion of brain
DUE TO Terminal bronchopneumonia
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20 AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1220 W. North Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): February 26, 1949 2 a.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Blunt force

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/12/49	Balto	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949 — REGISTRAR'S SIGNATURE
25 FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 St. Paul St.

VS 151

168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

G72262

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72262

BIRTH NO. | 91 | Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print): Alice McLaughlin

2. DATE OF DEATH: Mar. 8th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3502 Clifton Ave
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 11-2 Balto
D. STREET ADDRESS (If rural, give location): 139 W. Lafayette Ave

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Nov 5th 1876	72	4	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	—	Balto. Md	

13. FATHER'S NAME: Thomas McLaughlin

14. MOTHER'S MAIDEN NAME: Mary Gartland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Edgar T. Wagner	139 W. Lafayette Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of bladder and kidney	[illegible] years
DUE TO	Metastatic embolism	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Carcinoma bladder & kidney	1942
DUE TO		
(C)	—	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	—	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1942	Carcinoma of bladder & kidney	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Feb. 28th, 1949, *to* March 8th, 1949, *that I last saw the deceased alive on* March 8th, 1949, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. S. Gartland M. D.	1306 N. Calvert St. Balto.	March 8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/11/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 10 1949	[illegible]	Wm Cook Inc.	1217 St. Paul St.

VS 150

52a

G72263

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

441 G72263

Reg. Dist. No. 62

1. PLACE OF DEATH
COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1217 John St
MARYLAND
LENGTH OF STAY (In this place)

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE
STREET ADDRESS (If rural, give location) 1217 JOHN St. 11-2

3. NAME OF DECEASED (Type or Print): (First) CLARA (Middle) DOWNES (Last) HARDCASTLE
4. DATE OF DEATH (Month) MAR. (Day) 1 (Year) 1949

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH Aug. 27 1862
9. AGE last birthday 86 yrs. If under 1 year: Months 6, Days 4, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY housewife
11. BIRTHPLACE (State or foreign country) Caroline County
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Downes
14. MOTHER'S MAIDEN NAME Sallie Reines

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. none
17. INFORMANT Mrs Clara Whitby, 1217 John St. BALTIMORE 17

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause (a) Hypostatic [illegible]
Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) [illegible]
(c) [illegible]

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 27, 1949, to Mar. 1, 1949, that I last saw the deceased alive on Feb. 28, 1949, and that death occurred at 8:00 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John E. Wilson M.D. ADDRESS 3 W. Saratoga St. Balto. DATE SIGNED 3-1-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE Mar 3, 1949
NAME OF CEMETERY OR CREMATORY DENTON
LOCATION (City, town, or county) (State) DENTON, CAROLINE, MD.

DATE REC'D BY LOCAL REG. 3/2/49
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR J. Virgil Moore & Son
ADDRESS DENTON, MD.

MAR 1 0 1949

92D

G72264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72264

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. LAURA KETTERING

2. DATE OF DEATH 3/7/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQ. HOSP.

c. Length of stay in Baltimore Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY ~~CITY~~ Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.
D. STREET ADDRESS (If rural, give location) SHORE 100 Middle River

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	MARRIED	AUG 10 1882	66 67	8			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md	U.S.A

13. FATHER'S NAME Sam WATTS

14. MOTHER'S MAIDEN NAME Eliz. HUMPHREY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Hospital Asst	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism & broncho-pneumonia

DUE TO

(B) Auricular fibrillation

DUE TO

(C) Thyrotoxicosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Diffuse thyroid goiter.

INTERVAL BETWEEN ONSET AND DEATH
years.
?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 3/3 1949 *to* 3/7 1949, *that I last saw the deceased alive on* 3/7 1949 *and that death occurred at* 4:40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Fred Hawkins Jr M. D.	Franklin Square Hosp.	3/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/10/49	Oak Lawn	Eastern Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 10 1949	Beatrice Johnson Williams, M.D.	John J. Connolly	Essex, Md.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

62 B

G72265

BIRTH NO. B. 49006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

593

G72265
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Kenneth A. Curtis Jr.

2. DATE OF DEATH: March 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Bon Secours Hosp
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp
c. Length of stay in Baltimore: 5 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 714 Lynhurst St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Single	12-2-1943	5	3 7	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child	-	Baltimore MD	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Kenneth A Curtis	Rita A Curtis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-	-	-	Kenneth A Curtis	714 Lynhurst St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: month

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) nephritis — month

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: nephrosis — Oct. 1947

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 2/11/1949 to 3/9/1949, that I last saw the deceased alive on March 9, 1949, and that death occurred at 5:15 A.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. Strahler M.D.	Bon Secours Hosp.	3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-12-49	Cathedral Cem	Old Frederick Rd. Balto MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 10 1949	Huntington McMullen, M.D.	Bernard C Hurle	121 E Wood St

VS 150

121 E

G72266

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72266

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): GRACE J. HOSKINS WHITE

2. DATE OF DEATH: 3-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University

C. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2906 Windsor Ave.

5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 2, 1876
9. AGE (In years last birthday): 72 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James O. Hoskins
14. MOTHER'S MAIDEN NAME: Susan Rankin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO: no
17. INFORMANT: Mr. G. S. Hoskins — ADDRESS: 2926 Windsor Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT (The-kidney+spleen ??)

INTERVAL BETWEEN ONSET AND DEATH: 3-4 months

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-1 1949 to 3-8 1949, that I last saw the deceased alive on 3-8 1949, and that death occurred at 6 3/4 p m., from the causes and on the date stated above.

23A. SIGNATURE: John L. Sims M.D.
23B. ADDRESS: University Hosp
23C. DATE SIGNED: 3-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/12/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md

VS 150

20

G72267 ✓ X 420.1 G72267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) MYERS HOWARD JESTER

2. DATE OF DEATH 3-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Woodlawn
D. STREET ADDRESS (If rural, give location) 7323 Windsor Mill Rd.

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH May 27, 1883
9. AGE (In years last birthday) 65 yrs. If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Liquor Rectifier
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Myers S. Jester
14. MOTHER'S MAIDEN NAME Ella Sylvester

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-01-4981
17. INFORMANT Mrs. Anna M. Jester ADDRESS Woodlawn 7323 Windsor Mill Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 20 min
DUE TO: c acute pulmonary edema

(B) Hypertension or disease — 8 yrs +
DUE TO: c coronary sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——— 1941, *to* Mar. 9, 1949, *that I last saw the deceased alive on* Mar 1, 1949, *and that death occurred at* 8 29 m., *from the causes and on the date stated above.*

23A. SIGNATURE William P. Alagia M. D.
23B. ADDRESS 3316 Sidney St.
23C. DATE SIGNED 3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 3/11/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 10 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS
ADDRESS Balto., Md.

VS 150

93)

G72268

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72268

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph G Machin

2. DATE OF DEATH: 3-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: 84 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9
D STREET ADDRESS (If rural, give location): 1300 West Coldspring Lane Balto. 9, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	Widowed	Nov. 4, 1865	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph G Machin

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema — DUE TO

(B) Smoke asphyxiation — DUE TO

(C) Arterio-sclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 30 hrs

CERTIFICATION APPROVED BY
Wm. J. McClafferty, M.D.
For: C.J. Lubinski M.D.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.): home

21C. WHERE DID INJURY OCCUR? (Give City, give exact location): 1300 West Coldspring Lane

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 3 7 49 4p. m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Asphyxiation by smoke

22. I hereby certify that I attended the deceased from March 7, 1949, to March 8, 1949, that I last saw the deceased alive on March 8, 1949, and that death occurred at 9¼ p. m., from the causes and on the date stated above.

23A. SIGNATURE: John R. Smith, Jr. M. D.

23B. ADDRESS: Union Memorial Hosp.

23C. DATE SIGNED: 3 8 49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: March 11/49

24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge

24D. LOCATION (City, town, or county) (State): Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Lunatic C. Donaau

ADDRESS: 3638 Roland Ave.

VS 150

180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72269

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print): GEORGE C. WHITE

2. DATE OF DEATH: 3/8/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): EDGEWOOD NURSING HOME 6000 BELLONNA AVE.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1107 N. Sulton Ave. 16-4

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: May 31, 1859
9. AGE (In years last birthday): 89
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cabinet Maker
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): York, Penn.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: T. Kirk White
14. MOTHER'S MAIDEN NAME: ——— Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: George M. White
ADDRESS: 607 Druid Park Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocarditis
DUE TO Arterio-sclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: Several

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——— , 19 — , *to* ——— , 19 — , *that I last saw the deceased alive on* ——— , 19 — , *and that death occurred at* ——— m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. Healy M.D.
23B. ADDRESS: 1403 Park Ave
23C. DATE SIGNED: 3/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 3-11-49
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: George A. Farley
ADDRESS: Sulton Ave & Fayette St.

931

VS 150

G72270

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72270

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr. Edmond A. Freeman (ALBARTIS)

2. DATE OF DEATH 3-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 33rd. & Calvert Sts

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp

c. Length of stay in Baltimore 7 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE Md
B COUNTY Balt
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balt
D STREET ADDRESS (If rural, give location) 100 W. Univ. Parkway

5. SEX	6. COLOR OR RACE	7 SINGLE, MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Married	Oct. 31, 1868	80	4 / 9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
retired	Textile Industry	Tennessee	U.S.

13. FATHER'S NAME Moses (Moses) A. Freeman

14 MOTHER'S MAIDEN NAME Rose Bainbridge (Tennessee Rose Bainbridge)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	—		Mrs Julia M^c Clure Freeman	Balto. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Renal Abscess — INTERVAL BETWEEN ONSET AND DEATH: Month (?)

DUE TO

(B) Benign Prostatic Hypertrophy — yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
2-19-49	Benign Prostatic Hypertrophy	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-7, 19 49 *to* 3-9, 19 49 *that I last saw the deceased alive on* 3-9, 19 49 *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
John S. Green M.D	Union Memorial Hosp.	3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Mar-11-1949	Greenmount	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 10 1949	Registrar for Baltimore, Md	Stewart & Co.	North Ave

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

127a Baltimore #1.

G72271

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

80

G72271
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Marie Tanner King

2. DATE OF DEATH 3/7/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1906 W. Baltimore St

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-01
D. STREET ADDRESS (If rural, give location) 1906 W. Baltimore St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	9-4-1877	71	/	/

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At House	Maryland	USA

13. FATHER'S NAME Ernest Tanner

14. MOTHER'S MAIDEN NAME Caroline M. Winzek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Marian L. Payne ADDRESS 2922 Edmondson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of Rt Kidney — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1948	Nephrectomy - Adenocarcinoma	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1945 *to* March 7 1949, *that I last saw the deceased alive on* March 6 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. J. Lubicki M. D.	1925 W Baltimore St	3/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/10/49	Cedar Hill	Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 10 1949	Huntington Williams, M.D.	E. R. Gilbert & Son	5200 Old Eutaw Rd.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physician: please write the cause of death clearly and legibly.

G72272 BALTIMORE CITY HEALTH DEPARTMENT G72272

CERTIFICATE OF DEATH 331

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Frances Oles

2. DATE OF DEATH: Mar. 9-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1723 Gough St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 11

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

D. STREET ADDRESS (If rural, give location): 1723 Gough St.

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: Nov 29-187[illegible]

9. AGE (In years. If Under 1 Year last Birthday) Months Days / If Under 24 Hours Hours Min.: 77

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Martin Gajeski

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Marie Derda ADDRESS: 1723 Gough St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 24 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Arterial Hypertension — yrs.

DUE TO

(C) Generalized arteriosclerosis — yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar 7, 1949 *to* Mar 9, 1949. *That I last saw the deceased alive on* Mar 9, 1949 *and that death occurred at* 11:0 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo L Apley M. D.

23B. ADDRESS: 412 E Lafayette St Hosp

23C. DATE SIGNED: 3/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Mar 12-49

24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949

REGISTRAR'S SIGNATURE: Curtis Williams, Mgr

25. FUNERAL DIRECTOR: Wm. S. Fialkowski ADDRESS: 2007 Eastern ave

MARvs 1-50

83a

BRAUNS

G72273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72273

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Katherine D Brauns

2 DATE OF DEATH Mar 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 101 S Conkling

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE
B COUNTY 101 S Conkling Ave
c. CITY OR TOWN (If outside corporate limits write RURAL and give township) Balto
D STREET ADDRESS (If rural, give location) above

5. SEX	6. COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married	May 27 1870	78	9 / 12	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
at home		New York	

13. FATHER'S NAME

14 MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
		Mr Eberhard Brauns	101 S Conkling

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs.

DUE TO

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 10, 1948, to Mar 8, 1949, *that I last saw the deceased alive on* Mar 8, 1949 *and that death occurred at* 6 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Samuel Wolfe M. D.	1331 E. North Ave	3-9-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/11/49	Oak Lawn	Catonsville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 10 1949	Interington Williams, M.D.	Ulmer Funeral Home	3[illegible] Eutaw St

VS 150

931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72274

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72274

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print): FRANKLIN H. WAY

2. DATE OF DEATH: 10 MARCH 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE #24 L-2
D. STREET ADDRESS (If rural, give location): 436 NORTH KENWOOD AVE

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 07 NOV 1886
9. AGE (In years last birthday): 62 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: SCOTT WAY
14. MOTHER'S MAIDEN NAME: HANNAH HEVERN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: WIFE CARRIE R. ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1 MIN ??
DUE TO
(B) CORONARY ARTERIOSCLEROSIS — ? YEARS
DUE TO
(C) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE — ? YEARS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 MAR 1949 to 10 MAR 1949 that I last saw the deceased alive on 9 MAR 1949 and that death occurred at 12 15 A m., from the causes and on the date stated above.

23A. SIGNATURE: Donald F. England M.D.
23B. ADDRESS: MARYLAND GEN. HOSP.
23C. DATE SIGNED: 10 MAR 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/12/49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ulrich Funeral Home ADDRESS: [illegible]

VS 150

131a

G72275

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72275 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Dr. VICTOR F. CULLEN

2 DATE OF DEATH 3-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP 33rd & CALVERT ST

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md.
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-1
D STREET ADDRESS (If rural, give location) 3907 Cloverhill Rd.

5. SEX	6. COLOR OR RACE	7 SINGLE, MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	M	Sept. 5 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
PHYSICIAN	Tuberculosis Sat.	Funkstown, Md.	

13. FATHER'S NAME MARTIN EMMETT CULLEN

14 MOTHER'S MAIDEN NAME MARGARET COSHWA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
-		-	Mrs. Ethel Bell Cullen	3907 Cloverhill Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocardial Insufficiency 9 Yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22 *I hereby certify that I attended the deceased from* 3-9-49, 19 , *to* 3-9-49, 19 , *that I last saw the deceased alive on* 3-9-49, 19 , *and that death occurred at* 4:05 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Wm. P. Benson M.D. M.D.	Union Mem. Hosp.	3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/12/49	Rose Hill Cem.	Hagerstown, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 10 1949	Huntington Williams, Mgr	WM. J. TICKNER & SONS	Balto., Md.

VS 150

931

G72276

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

591 G72276
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sarah Ann White.

2. DATE OF DEATH: March 7, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 430 Eisler St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 430 Eisler St.
c. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 430 Eisler St.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 430 Eisler St. 22-2

5. SEX: Female
6. COLOR or RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: August 10 1870
9. AGE (In years last birthday): 66
If under 1 year: Months / Days
If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Zachariah Queen.
14 MOTHER'S MAIDEN NAME: Delia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17. INFORMANT: Viola Blacks ADDRESS 1430 Eisler St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemmorhage
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 3 Days

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/8, 1948, to 3/7, 1949 *that I last saw the deceased alive on* 3/5, 1949, *and that death occurred at* 30 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Daniel Trawick M. D.
23B ADDRESS: 122 N Dee St
23C DATE SIGNED: 3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-10-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949
REGISTRAR'S SIGNATURE: Lemuel Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R Williams
ADDRESS: 322 N. Schroeder St.

VS 150

121a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G722277

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 G722277 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alfred Lovell Southwick

2. DATE OF DEATH: March 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 221 Ridgemead Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

C. Length of stay in Baltimore: 15 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Maryland
B COUNTY: none
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 221 Ridgemead Road 12-1

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: May 25, 1881
9. AGE (In years last birthday) If Under 1 Year: Months Days If Under 24 Hours: Hours Min.: 67

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): news editor
10B KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Massachusetts
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: George Southwick
14. MOTHER'S MAIDEN NAME: Mary Lovell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Rodney L. Southwick ADDRESS: 3200 Highland Place, NW Wash., D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio - vascular
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertensive disease 5 yrs.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Feb 1, 1949 *to* Mar 9, 1949 *that I last saw the deceased alive on* March 9 1949 *and that death occurred at* 1 a *m., from the causes and on the date stated above.*

23A SIGNATURE: Homer U. Todd M. D.
23B ADDRESS: 2108 St Paul St
23C DATE SIGNED: 3/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): cremation
24B DATE: 3/11/49
24C NAME OF CEMETERY OR CREMATORY: Loudon Park
24D LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Pl.
Mitchell & Mitchell

VS 150

927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 4rl.4 G72278

BIRTH NO.

PRINT WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

1. NAME OF DECEASED (Type or Print): Ritta Kelly Douglas

2. DATE OF DEATH: March 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 101 W. 39th St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 101 W. 39th St. 12-1

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced
8. DATE OF BIRTH: Nov. 5, 1889
9. AGE (In years last birthday): 59 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Independence Mordecai Kelly
14. MOTHER'S MAIDEN NAME: Ritta Caroline Hammond
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Elizabeth D. Miller ADDRESS: 101 W. 39th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion — Interval between onset and death: 1
DUE TO
(B) Endocarditis — Interval between onset and death: 5 yrs
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____ 19 35 *to* Mar. 8, 1949 *that I last saw the deceased alive on* Mar 8 1949 *and that death occurred at* 11 30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Howard H Todd M.D.
23B. ADDRESS: 2108 St Paul St
23C. DATE SIGNED: 3/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 3/11/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949
REGISTRAR'S SIGNATURE: Emmington Williams, MD
25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Pl.
Mitchell & Mitchell

VS 150

92 E

G72279

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72279 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM J. PINCH, JR.

2. DATE OF DEATH March 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U. S. Marine Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Conneticut
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New London
D STREET ADDRESS (If rural, give location) 320 Pequot Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	12-22-08	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
warrant office	Coast Guard	Newport R.I.	U.S.A.

13. FATHER'S NAME: William J. Pinch

14. MOTHER'S MAIDEN NAME: Agnes Cronan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Records--U,S. Marine Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of skull

(B) Contusion of brain.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	street	Ordinance Road, ~~Baltimore~~ A.A. Co. County

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
Feb. 25, 1949 1a. m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	auto overturned

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
George G. Merrill M.D.		March 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	3/10/49		New London, Conn

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 10 1949	Thurston for Williams, M.D.	Robt C. & B. W. Walton - Pratt & Linden Sts

VS 151

170 c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G72280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450.0

Registered No. G72280

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SUSAN VIRGINIA PARKS

2. DATE OF DEATH 3-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTIMORE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6000 BELLONNA AVE.
c. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TOWSON
D. STREET ADDRESS (If rural, give location) 209 W. CHESAPEAKE AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	WIDOWED	OCT. 22, 1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MARYLAND	

13. FATHER'S NAME WM. STEPHENSON TREADWELL

14. MOTHER'S MAIDEN NAME VIRGINIA WINN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		S. ELMER PARKS	315 W. Pennsylvania Ave. TOWSON Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO Chronic Interstitial Nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Diabetes. Renal
DUE TO Arteriosclerosis

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Senility. Tuberculosis of Lungs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David H. Thompson M. D.	Towson 4. Md.	March 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	3-11-49	PROSPECT HILL	TOWSON Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 10 1949	Wm. Lester Williams, M.D.	John A. Moran	200 E. Baltimore

VS 150

61

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

G72281

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

410 Registered No. G72281

BIRTH NO.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Delia Gilwee

2. DATE OF DEATH: March 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Sec.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 518 Dunkirk Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	W	Widowed	Sept. 15, 1870	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		IRELAND	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Micheal Newell	Hnn Burke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Robert M. Gilwee	518 Dunkirk Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-vascular accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rheumatic CVD

DUE TO

(C) Mitral stenosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 8, 1949 *to* March 9, 1949 *that I last saw the deceased alive on* March 9, 1949, *and that death occurred at* 5:00 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. Shuhler M.D.	Bon Secours Hosp.	3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	3-12-49	ST. MARY, GOVAN.	BALTIMORE Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 10 1949	Municipal Registrar, Baltimore, Md.	John G. Moran	3000 E Balt St

VS 150

926

G72282

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420 Registered No. G72282

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES EDWARD TODD

2. DATE OF DEATH: March 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Somerset
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Crisfield
D. STREET ADDRESS (If rural, give location): 16 Maryland Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Single	10/22/1877	71	4	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Captain	Seafarer	Md.	USA

13. FATHER'S NAME: James Todd

14. MOTHER'S MAIDEN NAME: Harriett Summer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
?		?

17. INFORMANT: Records- US Marine Hospital — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteriosclerotic heart disease	Unknown
DUE TO -		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Generalized arteriosclerosis	Unknown
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Mar. 8, 1949, *to* Mar. 10, 1949 *that I last saw the deceased alive on* Mar. 10, 1949, *and that death occurred at* 5:15 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	US Marine Hospital, Balto, Md.	3/10/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	3/10/44	Crisfield	Crisfield, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR
MAR 10 1949	Huntington Williams M.D.	Tilly & Zeiler Inc 405 S. Temple St.

VS 150

93y

PRINT WITH TYPEWRITER, WRITE UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

550.1 Registered No. G72283

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HANDLIR, JOHN J.

2. DATE OF DEATH: Mar. 8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours
c. Length of stay in Baltimore: 63 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-2
D STREET ADDRESS (If rural, give location): 806 N. Kenwood Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	June 26	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waiter	Restaurant		

13. FATHER'S NAME: Joseph Handlir

14. MOTHER'S MAIDEN NAME: Josephine Zak

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Anna Lupinski Handlir	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Appendicitis, acute, ruptured (post-operative) — 3 days

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
4 March '49	Appendicitis - Peritonitis, generalized.	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 3 March, 1949, to 7 March, 1949, *that I last saw the deceased alive on* 7 March, 19 49, *and that death occurred at* 5:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Joseph R. Dolee, M. D.	Bon Secours Hospital	7 March 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	Mar. 11/49	Holy Redeemer	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 10 1949	Huntington Williams, M.D.	Jerome Cvachi	900 N. Chester St.

VS 150

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BIRTH NO. G72284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 0 G72284 Registered No.

1. NAME OF DECEASED (Type or Print): FRANCIS Thomas NULL

2. DATE OF DEATH: 10 MARCH 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE # 25
D. STREET ADDRESS (If rural, give location): 3627 COTTAGE AVE # 25

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 18 AUGUST 1871
9. AGE (In years last birthday): 77 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ANTIQUE DEALER
10B. KIND OF BUSINESS OR INDUSTRY: ←
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: SAMUEL NULL
14. MOTHER'S MAIDEN NAME: RACHEL MINTEN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): UNKNOWN
(If yes, give war or dates of service): ?
16. SOCIAL SECURITY NO.
17. INFORMANT: WIFE — ADDRESS: Mrs. Addie E. Null 3627 Cottage Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(1) (A) MYOCARDIAL INFARCTION, POSTERIOR — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS ?
DUE TO
(B) DIABETES MELLITUS WITH ACIDOSIS — 4 DAYS ??
DUE TO
(C) ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE — ?

ANTECEDENT CAUSES

(2) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: PNEUMONIA — 20 DAYS ?

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 8 MARCH 1949 *to* 10 MARCH 1949 *that I last saw the deceased alive on* 9 MAR 1949 *and that death occurred at* 12 30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Donald L. England M. D.
23B. ADDRESS: MARYLAND GEN HOSP
23C. DATE SIGNED: 10 MARCH 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/12/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

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PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 3-15-49

G72285 BALTIMORE CITY HEALTH DEPARTMENT G72285

CERTIFICATE OF DEATH

BIRTH NO. Registered No. 57

1. NAME OF DECEASED (Type or Print) Charles Edward Jubb

2. DATE OF DEATH 3-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md.
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 19
D STREET ADDRESS (If rural, give location) 1819 W. Baltimore St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	Widowed	3-26-1862	(87) 86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	U.S.A.

13. FATHER'S NAME Charles E. Jubb Sr

14. MOTHER'S MAIDEN NAME Rebecca Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Unk.		Mr. C. Elver Jubb	1819 W. Balto. St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1. (A) Coronary thrombosis, Terminal
DUE TO
(B) Arteriosclerotic C.V.D.
DUE TO
2. (C) Carcinoma Body of pancreas c metas to liver
DUE TO
(C) chronic cholecystitis c cholelithiasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Urinary bladder calculi
Prostatic obstruction

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-1-, 1949 *to* 3-10-, 1949 *that I last saw the deceased alive on* 3-10-, 1949 *and that death occurred at* 7:25 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. L. Rosser M.D.	University Hospital	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/14/49	Mt. Olivet Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Thomas J. Williams, Md.	WM. J. TICKNER & SONS	Balto., Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

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G72286

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72286

BIRTH NO.

1. NAME OF DECEASED (Type or Print): STEWART D. NIXON

2. DATE OF DEATH: March 8, 1948

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2539 Hollins St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2539 Hollins St. 20-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Widowed	Nov. 29, 1873	75	3 9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Furniture Finisher	Retired	Maryland	U. S. A.

13. FATHER'S NAME: William H. Nixon

14. MOTHER'S MAIDEN NAME: Ellen Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	212-12-2418A	William Nixon	721 N. Kenwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Interval between onset and death: 1 hr
DUE TO
(B) Chronic Myocarditis — 10 yrs.
DUE TO
(C) Cardio Vascular Renal Disease — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* January 1943 *to* March 1949, *that I last saw the deceased alive on* March 7, 1949, *and that death occurred at* 10:25 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Alvah H. Saunders, M. D.	4709 Harford Ave.	3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 11, 1949	Mt. Olivet	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949		George L. Schwab	2101 Frederick Ave.

VS 150

1312

G72287 G72287

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): John Howard Nyce Sr.

2. DATE OF DEATH: March 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Windsor Convalesing Home

C. Length of stay in Baltimore: Yrs. Life. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Maryland B. COUNTY Balto.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 3513 Hayward Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	Sept. 17, 1869	80 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Asst	American Ice Co.		U.S.A.

13. FATHER'S NAME: Joseph Crawford Nyce

14. MOTHER'S MAIDEN NAME: Mary Fallen Bosee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. John Howard Nyce ADDRESS 3513 Hayward Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteno-Sclerotic Heart Disease	2 years
DUE TO (B)	Generalized Arteno-Sclerosis	2 years
DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* December 1947 *to* March 7, 1949 *that I last saw the deceased alive on* 3/7/49, 19____, *and that death occurred at* 11 35 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Justus C. Bleich M. D.	5856 Reisterstown Rd	3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/11/49	Greenmount	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949		Loring Byers	500 St.

VS 150

93D

Please write the cause of death clearly and legibly. Physician: please write the exact age if especially important. Every item of information should be carefully supplied.

G72288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

776 Registered No. G72288

BIRTH NO. B.C. 49-04752

1. NAME OF DECEASED (Type or Print): Baby Carter

2. DATE OF DEATH: 2/28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctors, Hospital

C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 521 E. Baltimore St. 4-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White		2/26/49	New Born		2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Milton Carter

14. MOTHER'S MAIDEN NAME: Dorothy Naomi Setters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity 26 weeks old
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-26, 19 49, *to* 2/28/49, 19 49, *that I last saw the deceased alive on* 2-28, 19 49 *and that death occurred at* 5:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis Blanchard M. D.	816 Wolfe St	3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		University Medical School	MAR 8 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Municipal Registrar		

VS 150

159

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72289

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72289

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr Emmett Brown

2. DATE OF DEATH: Mar. 10, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland Home for Incurables

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home For Incurables 700 West 40th St

c. Length of stay in Baltimore: Yrs. 49 years Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY: Baltimore
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 208 Nothern Parkway

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W-	widower	MAY 14 - 1870	78	9	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Banker		Baltimore, Md	U S -

13. FATHER'S NAME: J. Badger Brown

14. MOTHER'S MAIDEN NAME: Katherine Parr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
unknown			Laura Fischer	700 W. 40th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Congestive Heart Failure	7 days
DUE TO (B)	Arteriosclerotic Cardio Vasc. Disease	10 years +
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Arthritis Deformans Multiple Joints	10 years +

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 18 1941, *to* March 10 1949, *that I last saw the deceased alive on* March 9 1949, *and that death occurred at* 4 12 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas Conway Wright M.D. M. D.	11 E. Chase St. Baltimore 2 MD	3/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Cremation	3/12/49	Freemount Cem	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 11 1949		H. H. Measerton 805 N. Calvert St

VS 150

92D

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72290
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72290
Registered No. 490

1. NAME OF DECEASED (Type or Print): (WENDELL) WELDON C. (SADDLER) SADLER (djm)

2. DATE OF DEATH: March 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 74 Kingston Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	March 13, 1919	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plumbers Helper		Baltimore, Maryland	

13. FATHER'S NAME: Arthur Sadler

14. MOTHER'S MAIDEN NAME: Suebelle ---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	213-07-1922	Mrs. Anna M. Sadler	74 Kingston Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Earl L. Royer M.D	[X]	3-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mr. 12, 1949	Oak Lawn Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Huntington Williams, MD	Philip Herwig Sons,	Edmondson Av

VS 151

10 8

G72291

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

416 Registered No. G72291

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Emerine

2. DATE OF DEATH 3/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 609 North Duncan Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Widowed	— 1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore	

13. FATHER'S NAME Geo. M. Emerine

14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Geo. M. Emerine ADDRESS 6608 Harford Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart Disease
DUE TO
(B) Pulmonary edema

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James McC. Finney M. D.	Union Memorial Hospital	3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/12/49	Oak Lawn	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Huntington Williams, M.D.	Philip Henry's Sons	2024 Orleans St.

VS 150

95B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72292 ✓X 160.5 G72292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C.49-02687

1. NAME OF DECEASED (Type or Print): GREGORY SMITH

2. DATE OF DEATH: 2/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland ~~Emergency Hospital~~

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. ~~Mos.~~ Days 1

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md. B COUNTY: Balto.
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pikesville, Balto
D. STREET ADDRESS (If rural, give location): Bellona Ave.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	C	S	2/10/49	—	—	18	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Balt. Provident Hosp., Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: not recorded — Smith

14. MOTHER'S MAIDEN NAME: not recorded - Maudie B. Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

17. INFORMANT: mother ADDRESS: above ✓

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis, Lung — DUE TO Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity — DUE TO Intracranial Hemorrhage — 36 hrs. unk

(C) Prematurity — 18 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
none	—	YES ✓ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 2/2/49 *to* 2/27/49 *that I last saw the deceased alive on* 2/27/49 *and that death occurred at* 5:30 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Sarah Cook M. D.	University Hospital	3/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
		University Medical School	MAR 4 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 1949	[illegible]	Commissioner of Health	

VS 150

160a

Sheet age is especially important. Physician: please write the cause of death clearly and legibly.

G72293 (Kustomutskis) KASTOMACKIS v no 1 G72293

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MADELINE (KUSTOMUTSK) KASTOMACKIS

2. DATE OF DEATH: March 9, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. General Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 709 Portland Street 72 or

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 1 Day: Hours / Min.
Female	White	married	?	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailoress		Lith.	?

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Alphonsus Selauskas	709 Portland St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Arteriosclerosis

DUE TO History of Epilepsy

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Fracture, nose

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	709 Portland Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
March 7, 1949 ? m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Fell down stairs (inside)

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
W. J. McClaffert M.D	[X]	3-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	March 14-49	Holy Redeemer	Belair Rd Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Thurlington Williams, III	Joseph Kasmskas Inc	85 602 Wash. Blvd

VS 151

Correct age is especially important. Physician: please write the cause of death clearly and forcibly.

G72294

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

102 Registered No. G72294

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES (SOMMERS) SUMMERS

2. DATE OF DEATH: March 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1317 Shields Palce

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Aug. 1896	52 (52)		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	

13. FATHER'S NAME: Frank Summers

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Rose Summers	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Pulmonary tuberculosis — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: none

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L. Royer, M.D.		3-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/12/49	Mt. Auburn	Westport, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Huntington Williams, M.D.	A. Halstead - 918 - Druid Hill Ave. 13B	

VS 151

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72295

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

156-1 Registered No. G72295

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hayami Hamilton

2. DATE OF DEATH: 3/8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY AA Co.

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Patapsco Dist

c. Length of stay in Baltimore: 25 Yrs. 3 Mos.

D. STREET ADDRESS (If rural, give location): 120 Bolton Ave Bolton

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	Married	6/4/94	54	8	19

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland Md	U.S.A.

13. FATHER'S NAME: Allen Hamilton

14. MOTHER'S MAIDEN NAME: Cora Jordan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Congestion ~~Carcinoma of Liver~~ edema

DUE TO

ANTECEDENT CAUSES

(B) Secondary CA Failure of Liver

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Carcinoma of Liver

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb 24, 1949, *to* March 8, 1949, *that I last saw the deceased alive on* March 8, 1949, *and that death occurred at* 5:50 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hall Wilder, M. D.	Provident Hospital	3/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-13-49	Mt Calvary Cem.	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Thaddeus Gibson / Witness, M.D.	Elroy O. Wilson	1005 Bentley Ave

VS 150

46 F

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G72296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59

G72296 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Melvin Lewis William

2. DATE OF DEATH: 3/8/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1643 e. Madison St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

c. Length of stay in Baltimore: II Yrs. (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 1643 E. Madison St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	Col.	Married	3/24/	4I				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Chester S c.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John William	Sarah William

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mary William	1643 E. Madison St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: Hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) Acute Glomerular Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 4 Months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—		YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 3rd, 1949 *to* March 8th, 1949 *that I last saw the deceased alive on* Mar. 8th, 1949 *and that death occurred at* 2:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Alan R. Lafond M. D.	5700 Bond St	3/10/49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	3/13/1949	Mt. Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Thurlington Williams, M.D.	Elroy O. Wilson	1000 Brantly Ave.

VS 150

107

Correct age is especially important. Physician: please write the cause of death clearly and fully.

G72297
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

570

G72297
Registered No.

1. NAME OF DECEASED (Type or Print): Mrs Mary Francis Adams.

2. DATE OF DEATH: March 10 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: 63 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17, 12 43
D. STREET ADDRESS (If rural, give location): 2340 Druid Hill Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	Colored	Widowed	4/1/73	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Charles Co Md	

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: Fannie Blair

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Peritonitis
DUE TO
(B) Perforated Ileum
DUE TO
(C) Mesenteric thrombosis •

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Arteriosclerotic Heart disease. + contributing

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 19 19 49 *to* March 10, 19 49, *that I last saw the deceased alive on* March 9, 1949, *and that death occurred at* 3 1/4 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip A. Reb M.D.	1400 N. Caroline St	March 10 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 14 49	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	for Huntington Williams, M.D.	V. Brooks	1463 N. Carey St

VS 150

123

G72298 ✓ 902.0 G72298

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LINA HAMBURGER HOCHSCHILD. N-803.7

2. DATE OF DEATH 3/9/1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland rear of Emersonian Apartments

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 85 Yrs. — Mos. — Days.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) Emersonian Apts. 13 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	6/24/1863.	85				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	U.S.A.

13. FATHER'S NAME Isaac Hamburger

14. MOTHER'S MAIDEN NAME Bettie Hamburger.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	Dr. Charles Austrian, 1417 Eutaw Place.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured Skull

DUE TO

(B) Cerebral Atrophy & Arteriosclerosis

DUE TO

(C) Marked depression

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Eutaw Place & Lake Drive

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 3 9 1949 3 p. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Fell out window 13/1

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE John R Lord M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED 3/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/11/1949.	Hebrew Friendship	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 11 1949

REGISTRAR'S SIGNATURE Huntington Robinson, M.D.

25. FUNERAL DIRECTOR Ward Goodman & Son. ADDRESS 1902 Eutaw Place.

VS 151

186a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72299

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160 G72299 Registered No.

BIRTH NO. BC-49-05221

1. NAME OF DECEASED (Type or Print): Minta Wilfred Seaborne

2. DATE OF DEATH: 3-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: Yrs. — Mos. 3 — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16
D. STREET ADDRESS (If rural, give location): 1127 N Carrollton Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro		3-3-49		3	3

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wilfred Malcalm Seaborne	Gwendolyn Fleming Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		mother	1127 N Carrollton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Breech Delivery

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hallstone M.D.	831 Harlem Ave	3/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Interred by family	3/11/49		

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 9 1949	Huntington Williams, Jr.		

VS 150

6

160a

Correct age is especially important. Physician: please write the cause of death clearly and forcibly.

G72300
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

49

G72300
Registered No.

1. NAME OF DECEASED (Type or Print): FANNIE SNYDER
2. DATE OF DEATH: 3-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai
C. Length of stay in Baltimore: 25 Yrs. ___ Mos. ___ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-16
D. STREET ADDRESS (If rural, give location): 4667 Park Heights Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): (Divorced)
8. DATE OF BIRTH:
9. AGE (In years last birthday): 62 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Herman Klug 4667 ADDRESS: Park Heights Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis & Hypertensive Heart Disease

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 18, 19 49 *to* March 10, 19 49, *that I last saw the deceased alive on* March 10, 1949, *and that death occurred at* 10:52 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Herman M Klaus M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 3/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-11-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Runs
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 11 1949
REGISTRAR'S SIGNATURE: Courtney Van Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

93D

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72301

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. | 53 | Registered No. G72301

1. NAME OF DECEASED (Type or Print): Fleischman, Mr. Bernard
2. DATE OF DEATH: Mar. 10, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital
C. Length of stay in Baltimore: 55 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Arundel Hotel

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widower	1-18-1867	82 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
merchant	-	Germany	U.S.

13. FATHER'S NAME: Moses Fleischman
14. MOTHER'S MAIDEN NAME: Ella Bierman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Church Home and Hospital Records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Transverse Colon spread to anterior abdominal wall

DUE TO

(B) Cachexia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Myocardial degeneration

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-16-49, 1949 *to* 3-10, 1949 *that I last saw the deceased alive on* 3-10, 1949, *and that death occurred at* 4:42 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. Kay Morrow, M.D.	Dorsey Home & Hosp.	Mar 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	3-13-49	Hebrew Herring Run	Balto	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Evelyn Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

46E

G72302 BS-129425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

416

G72302 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Kalakowski

2. DATE OF DEATH: March 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS

c. Length of stay in Baltimore: 25 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 544 S. 46th Street

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 1896?
9. AGE (In years last birthday): 53
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Julian Kalakowski
14. MOTHER'S MAIDEN NAME: Pauline Brodowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS*BALTO. CITY HOSP. ADDRESS: 4940 Eastern Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Rheumatic heart disease	?
	DUE TO		
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)		
	DUE TO		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-9- , 1949, *to* 3-10- , 1949, *that I last saw the deceased alive on* 3-10 , 1949, *and that death occurred at* 12:05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: G. S. Rozen M. D.
23B. ADDRESS: 4940 EASTERN AVENUE
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 3-14-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Wm. J. Fialkowski ADDRESS: 2007 Eastern Ave

VS 150

95B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4490 Registered No. G72303

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Marie Morini

2. DATE OF DEATH March 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 921 Stiles St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 37 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 921 Stiles St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male FE	White	Married	April 5 1883	65	11 / 3	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	Home	Alatri Italy	

13. FATHER'S NAME: Giovanni Pecci

14. MOTHER'S MAIDEN NAME: Giustina Gatta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: John Morini (Husband) ADDRESS: 921 Stiles St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: About 7 hrs.
DUE TO Lobar Pneumonia
(B) Pelvis
DUE TO
(C) Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. — 7 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 2, 1949, *to* March 8, 1949, *that I last saw the deceased alive on* Mar 8, 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	322 S. High St. Balto. Md.	3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 12 1949	Holy Redeemer Cemet.	Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	[signature]	[signature]	322 S. High St.

VS 150

61

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G72304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72304

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis 9nd Chelton Sr

2. DATE OF DEATH: MAR. 10, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

c. Length of stay in Baltimore: 54 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Parkville
D. STREET ADDRESS (If rural, give location): 3021 Linwood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	M	Aug. 11, 1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	Electrical Contractor	Baltimore, Md	USA

13. FATHER'S NAME: Frederick Chelton

14. MOTHER'S MAIDEN NAME: Blanche Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Miss H. Wallace	Church Home Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart Disease — Interval between onset and death: 30 yrs? 6 mos.

DUE TO Grade III - Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-9, 1949 *to* 3-10, 1949, *that I last saw the deceased alive on* 3-10, 1949, *and that death occurred at* 9:35 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lee M. Howard, M. D.	Church Home and Hosp.	3/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/12/49	Moreland Park	Balto MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Huntington Williams	Leonard J. Ruck	5305 Harford

VS 150

95B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

Dr. Brennan

G72305

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72305 Registered No.

1. NAME OF DECEASED (Type or Print): JOHN ADAM ZERHUSEN

2. DATE OF DEATH: Mar. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6304 Old Harford Road

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6304 Old Harford Road

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widowed	June 8, 1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Baltimore, Maryland	

13. FATHER'S NAME: Henry Zerhusen

14. MOTHER'S MAIDEN NAME: Catherine Streb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Mrs. Anne O'Brien	6304 Old Harford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Arteriosclerosis. — ?

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 27, 1949, *to* Mar 8, 1949, *that I last saw the deceased alive on* Mar 7, 1949, *and that death occurred at* 6:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas J Brennan M. D.	5217 Harford Road	3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-12-49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949		Leonard J. Ruck	5305 Harford Road.

VS 150

94a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G72506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143

G72506

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): THEODORE E. HUETTEL

2. DATE OF DEATH: March 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3214 Beverly Road

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
o STREET ADDRESS (If rural, give location): 3214 Beverly Road.

5. SEX	6. COLOR OR RACE	7 SINGLE, MARRIED WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	May 15, 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Engineer, Retired	Gas & Electric Co	Germany	

13. FATHER'S NAME: Theodore Huettel

14 MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension C.V.D.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Multiple Sclerosis

CERTIFICATION APPROVED BY
G. H. Merrill M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 3, 1949 *to* March 8, 1949 *that I last saw the deceased alive on* March 8, 1949, *and that death occurred at* 3:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
[illegible] M. D. M. D.	4218 Harford Rd.	3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/11/49	Parkwood	Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	[illegible]	William Cook, Inc.,	1217 St. Paul St.

VS 150

To be countersigned by Medical Examiner's office

93D

Exact age if special. Important. Physician: please write the cause of death clearly and legibly.

G72307 CERTIFICATE CORRECTED 3-16-49 ✓ 9-17-3 G72307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH E

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jesse J. Owens — N-803 ✓ — 2. DATE OF DEATH: 3-8-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md. General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): ~~(119 West St.)~~ 912 E. Eager St. 0-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	W	Married	Oct 22nd 1903	45	4	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Structural Iron Worker
10B. KIND OF BUSINESS OR INDUSTRY: Phillips Construction Co
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David Owens
14. MOTHER'S MAIDEN NAME: Lou Bradley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Pearl Owens — ADDRESS: 912 E. Eager St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Compound fracture of Skull — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Factory, Company
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Harford and 20th St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 3 9 49 12 Noon
21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Blunt force - Hit by boom on crane

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *thereon and from* Autopsy, Inspection or Inquiry *the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L. Long M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 3/9/49

24A. BURIAL, ~~CREMATION, REMOVAL (Specify)~~: Burial
24B. DATE: 3/12/49
24C. NAME OF CEMETERY OR CREMATORY: Morland Park
24D. LOCATION (City, town, or county) (State): Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 11 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 St. Paul St.

VS 151

176

G72308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20.1 G72308

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Frank J. Clunet

2. DATE OF DEATH: March 9, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4300 Roland Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4300 Roland Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 1 day: Hours	Min.
Male	White	Married	March 21, 1949	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Md. Casualty Co.	Baltimore, Md.	

13. FATHER'S NAME: Victor Clunet

14. MOTHER'S MAIDEN NAME: Mary Shannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No	212-10-3602	Mrs Edna M. Clunet, 4300 Roland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Thrombosis

DUE TO

(C) Senility

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/14/49, 19__, to 3-9-49, 19__, *that I last saw the deceased alive on* 3/9, 1949, *and that death occurred at* 11 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ira E Whitehill M. D.	230 E. University Pkwy	3/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	3/12/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 11 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

937

Please type or print. Important: Please write the cause of death clearly and fully.

G72309

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 Registered No. G72309

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNIE TINKER

2. DATE OF DEATH: March 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1633 Cliftview Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1633 Cliftview Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	About 1864	About 83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME: Thomas Raymond

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Mary Dove, 1633 Cliftview Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) [redacted]

DUE TO

(B) cerebral hemorrhage and arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/17/ , 1949, *to* 3/10 , 1949, *that I last saw the deceased alive on* 3/10/ , 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. Weiss M. D.	1927 E. Fourth Ave.	3-11-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/12/49	Parkwood	Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR ADDRESS
MAR 11 1949	[illegible] Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

83a

G725510 BS-86257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

007 G725510 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Preston Green

2. DATE OF DEATH March 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals

c. Length of stay in Baltimore 30 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 677 Franklin Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
MALE	NEGRO	MARRIED	March 14, 1918	30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	U.S.

13. FATHER'S NAME Edward Fisher

14. MOTHER'S MAIDEN NAME Rosa Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		RECORDS*BALTO. CITY HOSPITALS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary Tuberculosis far Advanced	5 yrs.
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ No ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-31, 1944 P *to* 3-9-, 1949, *that I last saw the deceased alive on* 3-9-, 1949, *and that death occurred at* 6:45 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. L. Rogers M. D.	4940 EASTERN AVENUE	March 10, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-12-49	Mt. Calvary Cem	A. A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949		Mrs Kate R. Williams	3224 Edmondson Ave

VS 150

130

G72511 Rosey G. Bell 1201 G72511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rosey G. Bell

2. DATE OF DEATH 3/4-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2511 Francis

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md 2511 Francis St B. COUNTY Balto Co

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto

D. STREET ADDRESS (If rural, give location) 2511 Francis St.

c. Length of stay in Baltimore Yrs. 13 Mos. 03 Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	W divorced	5/26 18	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Randalls Town Md	U.S.

13. FATHER'S NAME William White

14. MOTHER'S MAIDEN NAME Georganna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		None	Marshall D. Day	Co 2511 Francis St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/11, 19 49, *to* 3/4, 19 49 *that I last saw the deceased alive on* 3/4, 19 49, *and that death occurred at* 7 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas Smith M. D.	2134 W. Lexington	3/10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-13-49	Arbutus Memorial	Arbutus Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949		Mrs Katie R Williams	324 Schroeder St

VS 150

94a

G72312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72312

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE PLATER

2. DATE OF DEATH: March 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1527 W. Fairmount Avenue 19 07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Married	Dec. 25, 1890	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stall Attendant		Baltimore, Maryland	USA

13. FATHER'S NAME: John H. Weeks

14. MOTHER'S MAIDEN NAME: Stella Halstead

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	World War I		Rosetta Plater (wife)	1527 W. Fairmount Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl Royer MD per G. A. Merrill MD		3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-14-49	Balto. National Cem	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	[illegible]	Mrs Katie R. Williams	322 N Schroeder St

VS 151

939

G72313
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1949 Registered No. G72313

1. NAME OF DECEASED (Type or Print) WILLIAM ADELSBERGER

2. DATE OF DEATH March 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 902 West 38th Street 13 07

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	Married	May 31, 1897	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Molder Helper	Foundry	Md.	—

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Adelsberger.	Ella Maben.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1st W. W.	219-03-1225	Gladys Adelsberger	902 W. 38th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*
Autopsy, Inspection or Inquiry

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
H. J. McClafferty M.D.	[X]	March 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/14/49	Mount Lebanon Cemetery Co.	3/13/49 Balto.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Commissioner of Vital Statistics	Paul C. Schenemann	3615-17 Eastern Ave

VS 15½

108

G72314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

Registered No. G72314

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Fannie Schneider

2. DATE OF DEATH: 3/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3508 Chestnut Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
C. Length of stay in Baltimore: Yrs. — Mos. — Days —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 3508 Chestnut 1-3-06

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 10/29/1871
9. AGE (In years last birthday): 77
If Under 1 Year: Months — Days —
If Under 24 Hours: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: Wm H. Schneider
ADDRESS: 3508 Chestnut Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure

DUE TO

(B) Hypertensive cardiovascular disease

DUE TO

(C) arteriosclerosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* March, 1949, *to* March 8, 1949 *that I last saw the deceased alive on* 3/8, 1949, *and that death occurred at* 11 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 8429 Chestnut Av
23C. DATE SIGNED: 3/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/12/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Windsor Mill Rd

DATE RECEIVED BY LOCAL REGISTRAR: MAR 11 1949
REGISTRAR'S SIGNATURE: [signature] Registrar for Williams, M.D.
25. FUNERAL DIRECTOR: Paul E. Chenoweth Jr.
ADDRESS: 3405-11 Chestnut Ave

VS 150

931

G72315

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

34.1

G72315

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): M. Catherine Holz

2. DATE OF DEATH: 3-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. FRANKLIN SQUARE - E.A.W.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arbutus
D. STREET ADDRESS (If rural, give location): 1303 Birch Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
F	W	MARRIED	JUNE 10, 1907	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE		BALTO. MD	

13. FATHER'S NAME: JACOB SCHWIEGHEATH

14. MOTHER'S MAIDEN NAME: ELIZABETH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			MR. PETER HOLZ	1303 BIRCH AVE ARBUTUS - MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Congestive Heart Failure
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 3/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	MARCH 12 '49	LOUDON PARK	BALTO. MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Huntington Williams, M.D.	Harry A Wetzler	4101 EDMONDSON AVE

93E

G72316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

581.0

Registered No. G72316

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry H elwig

2. DATE OF DEATH: March 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 25-41
D. STREET ADDRESS (If rural, give location): 1705 Sulphen Springs Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	White	married	3-26-90	58	11	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	OWN BUSINESS	Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HARRY HELWIG	UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	205-12-5921	JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hepatic coma

DUE TO

(B) Cirrhosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-7, 1949 *to* 3-10, 1949 *that I last saw the deceased alive on* 3-10, 1949, *and that death occurred at* 3:40 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Colleran Dorsey M.D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	3-14-49	MEDOWRIDGE MEMORIAL PK	DORSEY, BALTO., MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 11 1949	Hunterstown Pennsylvania	Joseph F. Gambone, 321 Sulphen Springs Rd.

VS 150

124B

G72317

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44 Registered No. 72317

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Eula Carpenter

2. DATE OF DEATH: 7 Mar. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 920 Monroe St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 920 N. Monroe St.
C. Length of stay in Baltimore: 20yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 920 Monroe St 16 04

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Separated
8. DATE OF BIRTH: 9/15/1901
9. AGE (In years last birthday): 47 (If under 1 year: Months / Days; If under 1 day: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Culpepper, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Sanda Lee
14. MOTHER'S MAIDEN NAME: Middie Jackson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: R.L. Banks — ADDRESS: 920 Monroe St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammerer Jr. M.D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 7 Mar 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/12/49
24C. NAME OF CEMETERY OR CREMATORY: Nazareth Cemetery
24D. LOCATION (City, town, or county) (State): Boston Va.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas H. Hoffa
ADDRESS: 512 Canovas Ave

VS 151

1210

G72318

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4343 G72318 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) KATIE KELLUM

2. DATE OF DEATH 3/8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore City, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 40yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 327 N.Bruce Street 1901

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Married	10/20/1881	67	4	16		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Accomac, County, Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Severn Bevans	Nancy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT ADDRESS
No	-	-	Wm.Earl Kellum-327N.Bruce Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Organic heart disease. — Interval between onset and death: Many years indefinite

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B)
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 5 *1949, to* Mch. 8 *1949, that I last saw the deceased alive on* Mch 8 *1949, and that death occurred at* 9 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. Garland Abbott M. D.	1534 Druid Hill Ave	Mch. 11. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/12/49	Arbutus Mem'l. Pk	Balto. County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR ADDRESS
MAR 11 1949	Instructor Williams, M.D.	Charles G. Cooper-512 N.Carrollton Av.

VS 150

95c

G72319
JL 127269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

177 Registered No. G72319

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Williams

2. DATE OF DEATH March 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital 4940 Eastern Ave.

c. Length of stay in Baltimore 6 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1824 McCulloh St. 14-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
M	Negro	Sep.	May 25, 1860	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Richard Williams

14. MOTHER'S MAIDEN NAME Hester Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Generalized Metastatic Carcinoma	
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Carcinoma of Prostate	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Intestinal Obstruction due to Inguinal Hernia	

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 3, 1949 *to* March 9, 1949 *that I last saw the deceased alive on* March 9, 1949 *and that death occurred at* 8 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED 3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 3/12/49

24C. NAME OF CEMETERY OR CREMATORY Mt Zion

24D. LOCATION (City, town, or county) (State) Balto County

DATE RECEIVED BY LOCAL REGISTRAR MAR 11 1949

REGISTRAR'S SIGNATURE [signature]

25. FUNERAL DIRECTOR Charles Harper ADDRESS 512 Canden Ave.

VS 150

512

G72320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72320 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DAISY M. MAJOR

2. DATE OF DEATH: 3/9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland I228 Hanover Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): I228 Hanover Street 23-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
F	W	M	2/I7/I9I6	33	--- / 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housework	at home	Baltimore, Maryland	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Family - Same	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pulmonary Tuberculosis	7
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Mitral regurgitation of heart	2 years (?)
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	- - - -	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	- - - -	- - -

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
- - - - m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	- - - -

22. *I hereby certify that I attended the deceased from* 2/15, 1948 *to* 3/9, 1949 *that I last saw the deceased alive on* 2/28, 1949, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Deibel M. D.	1226 Hanover Street,	3/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/12/49	Cedar Hill	Brooklyn, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Beatrice [illegible] Williams, Mgr.	Thos. J. McCully	130 E. Fort Ave.

VS 150

13B

G72521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72521

Registered No. 175

BIRTH NO. B.C. 49-04543

1. NAME OF DECEASED (Type or Print): BABY BOY SMITH

2. DATE OF DEATH: Feb. 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-01
D. STREET ADDRESS (If rural, give location): 620 N. Carrollton Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
Male	Col.	Infant	-	0	0	0	3	15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-	-	Baltimore, Md.	-

13. FATHER'S NAME: Otha Junior Lucas - N. C.

14. MOTHER'S MAIDEN NAME: Dora Smith - Balto., Md.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
-	-	-	Mother	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Atelectasis

DUE TO

(B) Prematurity

DUE TO

(C) Previable 26 wk. old infant weight 1 lb. 13 oz.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
-	-	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
-	-	-

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
- m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	-

22. *I hereby certify that I attended the deceased from* Feb. 27, 1949 *to* Feb. 27, 1949, *that I last saw the deceased alive on* Feb. 27, 1949 *and that death occurred at* 11 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C DATE SIGNED
Ben Bold M.D. M. D.	University Hospital	Feb. 27, '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		University Medical School MAR 4 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

159

G72322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72322

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. EMMA JANE DORSEY

2. DATE OF DEATH: March 11. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1151 N. Stricker St.

c. Length of stay in Baltimore: Yrs. 2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1151 N. Stricker St. 16-07

5. SEX: F.
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec 25 1867
9. AGE (In years last birthday): 82 Years — If under 1 year: Months / Days; If under 24 hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home - wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frederick City Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Lewis Hill
14. MOTHER'S MAIDEN NAME: Jane Hinson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Ralph T. Hill ADDRESS: 22 Classic St. Westminster. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Transverse (Transverse) Colon 2 yrs.
DUE TO Metastasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 20, 1948 *to* Mar. 11, 1949 *that I last saw the deceased alive on* March 11, 1949, *and that death occurred at* 9:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Jas. S. Julian Jr. M. D.
23B. ADDRESS: 511 N. Schroeder St. Balto.
23C. DATE SIGNED: 3/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 14. 49
24C. NAME OF CEMETERY OR CREMATORY: Ellsworth Cemetery
24D. LOCATION (City, town, or county) (State): Westminster Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 11 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: J. E. Myers. Jr.
ADDRESS: Westminster Md.

VS 150

46E

G72323

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

761.5 G72323

Registered No.

BIRTH NO. B-Cm49-03914

1. NAME OF DECEASED (Type or Print): William Earl Omaro Jr

2. DATE OF DEATH: 2/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 123 W Perry St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year last birthday) Months	Days	If under 24 Hours Hours	Min.
M	N	Single	2/22/49		2	13	6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Earl Omaro
14. MOTHER'S MAIDEN NAME: Doris Cecelia Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs Doris Omaro ADDRESS: 123 W Perry St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity, Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs 24

DUE TO

(B) Polycythemia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-22 *1949 to* 2/25 *, 1949 that I last saw the deceased alive on* 2/25 *, 1949 and that death occurred at* 12:15 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. Louis Young, M. D.
23B. ADDRESS: 1100 Druid Hill Ave
23C. DATE SIGNED: 2/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: University Medical School MAR 11 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY REGISTRAR: MAR 11 1949
REGISTRAR'S SIGNATURE: Commissioner of Health
25. FUNERAL DIRECTOR:
ADDRESS:

VS 150

159

G72524

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. | Registered No. 331 | G72524

1. NAME OF DECEASED (Type or Print): Rae Summers Moran
2. DATE OF DEATH: March 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3205 Elgin Ave.,
C. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3205 Elgin Ave., 15-47

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Divorced	Aug. 4, 1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Registered Nurse		Maryland	

13. FATHER'S NAME: Charles S. Moran
14. MOTHER'S MAIDEN NAME: Theodosia Ridgeway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Charles Moran	4429 Clifton Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis (Hypertension) — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1939 *to* Mar. 9, 1949, *that I last saw the deceased alive on* 3/8, 1949 *and that death occurred at* 6 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J Homer C Todd M. D.	2108 St Paul St	3/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/12/49	Loudon Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Evelyn for Williams, M.D.	G. Howard Strong	3207 W. North Ave.

VS 150

83a

G72325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72325

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Alma Cost

2. DATE OF DEATH: March 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged Poor

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): Valley & Preston Sts. 10 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
F.	W.	W.	April 7, 1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-		Balto., Md.	

13. FATHER'S NAME: William Ferguson

14. MOTHER'S MAIDEN NAME: Winifred Fullam

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Lilian Tyndall ADDRESS: 1200 Valley St. Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mitral Stenosis — Interval between onset and death: 5 yrs

DUE TO

(B) Chronic Myocarditis — 10 yrs

DUE TO

(C) Cerebral Arteriosclerosis — 10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 2 — 1949 *to* March 10 — 1949, *that I last saw the deceased alive on* March 10 1949, *and that death occurred at* 4-30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Gill Hall M. D.	1631 E North ave	March 11 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-14-49	Druid Ridge Cem.	Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Huntington Williams, Jr.	Wm. J. Dickey & Son	Balto. Md.

VS 150

92 B

G72326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 360

G72326

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Fannie Myers

2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4613 Park Hgts. Ave. Mt. Sinai Nursing Home

c. Length of stay in Baltimore: 2 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 4613 Park Heights Ave. 27-16

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months Days	If under 24 hours: Hours Min.
female	white	married	1872	76 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Poland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Fevel Eisenburg	- unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

DUE TO

(B) Arteriosclerosis, generalized

DUE TO

(C) Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1947, *to* March, 1949, *that I last saw the deceased alive on* March 11, 1949, *and that death occurred at* 9:05 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Samuel V. Montgomery M. D.	3600 Park Heights Ave	Mar 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	3/11/49	-	Norfolk, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 11 1949	Huntington Williams M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

61

G72327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 G72327

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen Louise King

2. DATE OF DEATH: March 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3801 Roland Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3801 Roland ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Single	About 53			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME: Joseph S. King

14. MOTHER'S MAIDEN NAME: Helen Boyle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Francis L. King ADDRESS: 902 E. Belvedere Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Virus pneumonia. — INTERVAL BETWEEN ONSET AND DEATH: Jan 29 '49 to Mar 10

DUE TO

(B) Hypertensive Cardio Vascular disease

DUE TO

(C) (Acute Heart Failure (Cause))

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
✓	✓	✓

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	✓

22. *I hereby certify that I attended the deceased from* Jan 29, 1949 *to* Mar 10, 1949 *that I last saw the deceased alive on* 3/10, 1949, *and that death occurred at* 10-40 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Reuben E Steele M. D.	10 W. Madison St.	3-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar. 14, 1949	Cathedral	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR ADDRESS
MAR 11 1949	Writing for Williams, Jr.	H. H. Mears & Son 805 N Calvert St.

VS 150

93D

G72528

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72528

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Grayld Jones

2. DATE OF DEATH: March 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md; B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1028 Sterling St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 1028 Sterling St. 10-01

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 20, 1880

9. AGE (In years last birthday): 68 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country): Charles County Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Jones

14. MOTHER'S MAIDEN NAME: Gertrude Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 218 10 5565

17. INFORMANT: Marie Jones ADDRESS: 1028 Sterling St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of oesophagus — INTERVAL BETWEEN ONSET AND DEATH: 6 Mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12/49

19B. MAJOR FINDINGS OF OPERATION: Carcinoma - oesophagus

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/13 1948 to 3-8 1949 that I last saw the deceased alive on 3-6 1949 and that death occurred at 9 Lp m. from the causes and on the date stated above.

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: RAYNER BROWNE, M.D. 1500 EAST MADISON ST BALTIMORE MD

23C. DATE SIGNED: 3-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: March 12/49

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.

24D. LOCATION (City, town, or county) (State): Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 11 1949

REGISTRAR'S SIGNATURE: Lemuel Williams, M.D.

25. FUNERAL DIRECTOR: Mc Pott & Elliott ADDRESS: 46a 1129 N. Carrollton

VS 150

6772529

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6772529

BIRTH NO. Registered No. 1949

1. NAME OF DECEASED (Type or Print): MRS. FRANK K. RAMSAY (MARY BERTHA)

2. DATE OF DEATH: MARCH 11 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution - residence before admission)
a. STATE: MARYLAND
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): STREET
d. STREET ADDRESS (If rural, give location): —

5a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

5c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: MARCH 22 1892
9. AGE (In years last birthday): 56 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: JOHN BILES
14. MOTHER'S MAIDEN NAME: ELLEN JANE PYLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: HOSPITAL RECORDS — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Retroperitoneal sarcoma with
DUE TO
(B) intestinal implement of sigmoid and retroperitoneal space.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

19a. DATE OF OPERATION: MARCH 2, 1949
19b. MAJOR FINDINGS OF OPERATION: LARGE MASS IN LEFT LOWER QUADRANT (SEE CAUSE OF DEATH)
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MARCH 4, 1949, to MARCH 11, 1949, that I last saw the deceased alive on MARCH 11, 1949, and that death occurred at 7:25 P m., from the causes and on the date stated above.

23a. SIGNATURE: Mortimer Lee Williams M. D.
23b. ADDRESS: UNION MEMORIAL HOSPITAL
23c. DATE SIGNED: MARCH 11, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: March 15 1949
24c. NAME OF CEMETERY OR CREMATORY: Emory
24d. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 11 1949
REGISTRAR'S SIGNATURE: Registrar for Baltimore, Md.
25. FUNERAL DIRECTOR: [illegible] — ADDRESS: [illegible]

VS 150

46H

G72330

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72330 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Ennis

2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours
c. Length of stay in Baltimore: Yrs. 9 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Worcester
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ocean City
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3/28/08
9. AGE (In years last birthday): 40 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Sharon Md
12. CITIZEN OF (WHAT COUNTRY): America
13. FATHER'S NAME: Eldridge Ennis
14. MOTHER'S MAIDEN NAME: Bessie Coffin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs E. Ennis, ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Adenocarcinoma Stomach — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Coronary Heart Disease

INTERVAL BETWEEN ONSET AND DEATH: 9 months

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/10/, 1949, to 3/11/, 1949 that I last saw the deceased alive on March 11, 1949, and that death occurred at 10:45 Pm., from the causes and on the date stated above.

23A. SIGNATURE: D. S. Mahler, M. D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 3/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/13/49
24C. NAME OF CEMETERY OR CREMATORY: I O O F
24D. LOCATION (City, town, or county) (State): Bishopville, Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: M. Pasha Watson, ADDRESS: Salisbury, Md

VS 150

46B

G72331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

99-8 G72331

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) August Gajewski

2. DATE OF DEATH 3-10-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4319 S Hanover Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	W	7-16-82	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor
10B. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U.
13. FATHER'S NAME Michael Gajewski
14. MOTHER'S MAIDEN NAME Antoinette Jurczyk
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215056592
17. INFORMANT Felix Gajewski ADDRESS 4319 S Hanover Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Carcinomatosis — DUE TO
(B) Adenocarcinoma - Site of origin undetermined — DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: Approx 8 mos

19A. DATE OF OPERATION 8-25-48
19B. MAJOR FINDINGS OF OPERATION Omental metastases
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-18 19 49 to 3-10 19 49 *that I last saw the deceased alive on* 3-10 19 49, *and that death occurred at* 3:43½ p m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.
23B. ADDRESS Mercy Hosp
23C. DATE SIGNED 3-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE March 14 49
24C. NAME OF CEMETERY OR CREMATORY Holy Sepulchre
24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR MAR 12 1949
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR Fred W Ozazewski ADDRESS 1930 55E Eastern Ave

VS 150

G72332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72532

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HOWARD M. EMMONS

2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3302 Walbrook Avenue
c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3302 Walbrook Ave. 15 06

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
male	white	widowed	Nov. 15, 1865	83 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		Baltimore, Md.	

13. FATHER'S NAME: Herman L. Emmons

14. MOTHER'S MAIDEN NAME: Jane L. Burgess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Miss Marion Emmons	3302 Walbrook Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Congestive heart failure	three weeks
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Heart damage from three attacks of coronary occlusion	4 years
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Hypertension	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 29, 1949, *to* 3-10-, 1949, *that I last saw the deceased alive on* 3-10-, 1949, *and that death occurred at* one P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Maurice E. Shamer M.D.	3300 W. Mulberry (16)	3/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/14/49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 12 1949		WM. J. TICKNER & SONS	Balto., Md.

VS 150

94a

G72333 X 354.4 G72333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jean Hofmeister

2. DATE OF DEATH: March 11 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 2 Weeks (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Cave Rd Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Owings Mills
D. STREET ADDRESS (If rural, give location): Cave Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White		9-28-47	1-5-12	18	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Walter Hofmeister

14. MOTHER'S MAIDEN NAME: Mary Barrett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Cerebral thrombosis	13 days
DUE TO		
(B)	Polycythemia	Lifetime
DUE TO		
(C)	Congenital Heart disease, Cyanotic type	Lifetime

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/27 *to* 3/11, 1949, *that I last saw the deceased alive on* 3/11, 1949, *and that death occurred at* 11 55 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard Vanduyk M. D.	JOHNS HOPKINS HOSPITAL	March 11 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/13/49	St. Charles	Pikesville, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
3/14/1949	Registrar for Williams, M.D.	Frank H. Newell Inc

VS 150

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157E

G72334

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72334

1. NAME OF DECEASED (Type or Print): JOHN ANDREW KNIGHT

2. DATE OF DEATH: March 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1125 East North Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1125 E. North Ave. 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	Dec. 16, 1865	83	2 / 24	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Baltimore, Md.	

13. FATHER'S NAME: George H. Knight

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
NO		John A. Knight, 2031 E. 32nd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Chronic Valvular Endocarditis	3 years
DUE TO (B)	Hypertension	5 years
DUE TO (C)	Senility	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	None	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 27th, 1949 *to* March 10th, 1949, *that I last saw the deceased alive on* March 9, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. L. Gundy M. D.	5106 Harford Rd	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/14/49	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
MAR 12 1949	[illegible] for Baltimore, Md.	William Cook, Inc., 1217 St. Paul St.

VS 150

92D

G72335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Ser. No. 1

G72335 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. Thomas E Bryan

2. DATE OF DEATH: 3-11-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 2412 St. Paul St. 12 6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Single	Oct 27th 1881	67	4	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Property Sales Co	Md.	

13. FATHER'S NAME: Thomas Bryan

14. MOTHER'S MAIDEN NAME: Annie E. Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	217-220-337	Mrs Raymond Bryan	12 E. Lanvale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis & Heart Block (Left Bundle Branch), Arteriosclerosis and Cardiac Failure grade III — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Arterio & Chronic C. V. Disease

DUE TO (C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Marasmus Senilis Dec. Hemorrhage & Fecal Impaction — 2 Days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1 March 1949 *to* 11 March 1949 *that I last saw the deceased alive on* 11 March 1949 *and that death occurred at* 9 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Orlin R Hemmeringer M. D.	University Hospital	3-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/13/49	Chesterfield	Centreville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 12 1949	Huntington Williams M.D.	Wm Cook Inc.	127 St. Paul St.

VS 150

93D

G72336

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72336

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): August Maher
2. DATE OF DEATH: 3/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1635 N. Gay st

5. SEX: Male
6. COLOR OR RACE: White
7. ~~SINGLE, MARRIED~~ WIDOWED ~~DIVORCED~~ (Specify): Widowed
8. DATE OF BIRTH: Jan 2 1887
9. AGE (In years last birthday): 60 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bottler
10B. KIND OF BUSINESS OR INDUSTRY: American Brewery
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Maher
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: August Maher Sr. ADDRESS: 1635 N. Gay st

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Renal carcinoma c metastases
DUE TO to liver, lung, pleura, spine

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 25 1949 *to* March 11 1949 *that I last saw the deceased alive on* 3/11 1949 *and that death occurred at* 1 40 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marjorie Berman, M.D. M. D.
23B. ADDRESS: Sinai Hospital, Baltimore
23C. DATE SIGNED: 3/11/49

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify): Burial
24B. DATE: 3/15/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Balto
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE: Curtis Fox Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc ADDRESS: 1217 St. Paul st.

VS 150

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G72337 Dr Friedman 404 E North Ave G72337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1 20 G72337

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROY OTIS TATEM

2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 227 E. Lafayette Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 227 E. Lafayette Ave. 12 c 5

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Divorced	Dec. 9, 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk, Retired	Railroad	Asbury, N.J.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Randolph Tatem	Anna I. Battley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No	259-20-1870	Sidney A. Tatem, 227 E. Lafayette Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO

(C)

CERTIFICATION APPROVED BY
H. J. McClafferty M.D.
CHIEF OR ASST. MED. EXAM.

INTERVAL BETWEEN ONSET AND DEATH: ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 11, 1949, *to* March 11, 1949 *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 1:25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph Friedman M.D.	404 E. North Ave.	March 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	3/12/49	Atlanta	Atlanta, Gengia

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 12 1949	Curtis for Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

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G72338

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72338

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES ANDRE RULEY

2. DATE OF DEATH: 3/11/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3107 Batavia Avenue

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3107 Batavia Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months Days	If under 24 hours: Hours Min.
Male	White	Married	1874	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Guard	Balto. Contracting	Baltimore	

13. FATHER'S NAME: Samuel H. Ruley

14. MOTHER'S MAIDEN NAME: Laura J. Klein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	341-22-5120	Mr. Charles B. Ruley 3107 Batavia Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: 5 yr

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____ 19__ *to* Mar. ____, 1949 *that I last saw the deceased alive on* Mar. 10, 1949 *and that death occurred at* 4:45A *m, from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
Edward Horak	101 W. Read St	3-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/14/49	Oak Lawn Cemetery	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 12 1949	Contingent Williams, M.D.	WIEDEFELD & SON GREENMOUNT AVE & 22nd

VS 150

93D

G72339

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72339

1. NAME OF DECEASED (Type or Print): Christopher Zizzi

2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 629 S. Potomac St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 629 S. Potomac St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	August 4, 1895	53	7	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Coppersmith		Baltimore, Md.	

13. FATHER'S NAME: Emiveo Zizzi

14. MOTHER'S MAIDEN NAME: M. Meisenzahl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No.			Mrs. Elizabeth Zizzi	629 S. Potomac St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Occlusion	1 hr.
DUE TO (B)	Coronary Sclerosis	3 yrs.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Arteriolar Hypertension	9 yrs.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1947, *to* March 11, 1949, *that I last saw the deceased alive on* March 5th, 1949, *and that death occurred at* 6:00 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Clarence W. LeBoeuf, M. D.	3023 Eastern Ave.	3/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar. 14, 1949	Baltimore	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 12 1949	Christopher Williams, M. D.	Wm. J. Tunnell Home	2008 Orleans

94a

G72340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 Registered No. G72340

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Herman R. Thomas

2. DATE OF DEATH: March 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 807 N. Broadway
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days: 7 - 05

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 807 N. Broadway

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Widowed	July 4, 1873	75	8	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Inspector		Baltimore, Md.	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No.			Albert Thomas	2121 E. Monument St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Cerebral Hemorrhage	3 days.
DUE TO		
(B)	Hypertension	?
DUE TO		
(C)	Cerebral toteris-sclerosis	?
	Chronic myocarditis	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 9, 1949, *to* March 10, 1949 *that I last saw the deceased alive on* Mar. 10, 1949 *and that death occurred at* 24 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank M. Ogden M.D.	2701 N. Calvert St	Mar. 10, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar. 12, 1949	Parkwood	Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 12 1949	Instructor Williams, M.D.	Ullrich Funeral Home	2008 Orleans St.,

VS 150

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G72541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72541

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RICHARD WOODALL WILLIAMS

2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 6702 North Point Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	Married	Sept. 9, 1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Eng.	seafarer	Balto, Md.	USA

13. FATHER'S NAME: Jonathan Williams

14. MOTHER'S MAIDEN NAME: ? Wilson, .

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
NO		Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Myocardial infarction, acute	Unknown
DUE TO (B)	Arteriosclerotic heart disease, chronic	Unknown
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

CERTIFICATION APPROVED BY
For: W.G. Helfrich, M.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Mar. 11, 1949, *to* Mar. 11, 19 49 *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* DEAD ON ARRIVAL 8:10AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
John L. Wilson M.D.	US Marine Hospital, Balto Md.	3/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/14/49	Oak Lawn	7225 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR ADDRESS
MAR 14 1949	[illegible]	Clarence F. Hoffmann 1639 Broadway.

VS 150

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Dr. Machen
G72342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72342 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE ALFRED WASHINGTON

2. DATE OF DEATH: Mar. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6416 Rosemont Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 6416 Rosemont Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Oct. 6, 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
at home		England	

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
John Washington	May Flegg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
	212-05-3946	Mrs. Clara Washington	6416 Rosemont

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	MYOCARDIAL DEGENERATION	10 DAYS
DUE TO (B)	PULMONARY HEART DISEASE	8 YRS +
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	CHRONIC BRONCHITIS and PULMONARY EMPHYSEMA	8 YRS +
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	ARTERIOSCLEROSIS	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/14, 1940, *to* 3/10, 1949, *that I last saw the deceased alive on* 3/10, 1949, *and that death occurred at* 6:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C DATE SIGNED
M. D.	633 Belair Rd (6)	3/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3-14-49	Oaklawn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	[illegible]	Leonard J. Ruck	5305 Harford Road

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G72343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72343 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN F. DARE	2. DATE OF DEATH: March 11, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital c. Length of stay in Baltimore: Yrs. Mos. Days	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 525 Wilson Street 14 0 7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	5-16-1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
N		Maryl nd	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nelson Dare	Evelyn Coates

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Bessie Dare	5353 Wilson Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio Vascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Ins. & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from; natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

Autopsy, Inspection or Inquiry

23A. SIGNATURE	23B.	23C. DATE SIGNED
W. J. McClafferty, M.D	CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	3-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-15-49	Arbutus	Mayland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 2 1949	Huntington Williams, M.D.	George G. Kelson	1303 Presstman St.

VS 151

93D

G72344 — 592 — G72344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 592

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Reinhardt G. Liebenow

2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged Poor

C. Length of stay in Baltimore: Yrs. 10 Mos. 01 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M.	W.	W.	Dec. 27, 1857	91				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		—	

13. FATHER'S NAME: Julius Liebenow

14. MOTHER'S MAIDEN NAME: Amelia Baebedy.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Sister Ignatius ADDRESS: 1200 Valley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Chronic Myocarditis	5 yrs
DUE TO		
(B)	Arterio Sclerosis	10 yrs
DUE TO		
(C)	Chronic Nephritis	10 yr

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 1 , 1949, *to* March 10 , 1949, *that I last saw the deceased alive on* March 11 , 1949, *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E Gill Hall M. D.	1631 E. North ave	March-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	3/14/49	Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR. ADDRESS
MAR 12 1949	Penrhyn Williams, M.D.	Rita Wiedefeld 900 E. Biddle St

VS 150

131a

G72545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72545

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catharine Elseman

2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for the aged Room

c. Length of stay in Baltimore: Yrs. 10 Mos. 01 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F.	W.	W.	Nov 5, 1860	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		—	

13. FATHER'S NAME: Jacob Miesberger

14. MOTHER'S MAIDEN NAME: Cath. Shoeman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (Signature) ADDRESS: 1200 Valley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO

(B) Arterio Sclerosis — 10 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10 1949, to Mch 11 1949, that I last saw the deceased alive on Mch 11 1949, and that death occurred at 8 a m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. Gill Hall M. D.	1631 E. North Ave	Mch 13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 14 1949	Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 12 1949	Huntington Williams, M.D.	Rita Wedefeld	900 E. Biddle St

VS 150

93

G72346

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72346

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catherine Schofield

2. DATE OF DEATH: March 11/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland — Balto. Md.
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Schneider Nursing Home 4700 Harford Rd.
c. Length of stay in Baltimore: 19yrs (Yrs. / Mon. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
b. COUNTY
4615 Harford Rd.
c. CITY OR TOWN (If outside corporate limits, write RFD and give township): Balto. Md.
d. STREET ADDRESS (If rural, give location): 4615 Harford Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Sept. 25, 1864	84	5 / 16	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
none	-----	Germany	

13. FATHER'S NAME: Christian Schofield

14. MOTHER'S MAIDEN NAME: Elizabeth Clund

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
--	--	--	Mrs. Wittmer	4615 Harford Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
I (A) Bronchopneumonia
DUE TO
(B) Arteriosclerotic C.V.D.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 48hrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 15 *to* Mar. 11, 1949 *that I last saw the deceased alive on* Mar. 11, 1949 *and that death occurred at* 10.05 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M.D.	4615 Harford Rd.	3/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Removal	Mar. 13/49	Saginaw Mich	Saginaw Mich

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 12 1949	[signature]	Philip Sterling Sons	2024 Orleans st

VS 150

930

G72347

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 98 ✓ Registered No. G72347

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE THOMPSON N-874 ✓

2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1810 Park Avenue
C. Length of stay in Baltimore: 4 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1810 Park Avenue 13-07 ✓

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH:
9. AGE (In years last birthday): 60 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Roofing Co
11. BIRTHPLACE (State or foreign country): Tenn
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thompson
14. MOTHER'S MAIDEN NAME: — —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 240-16-8462
17. INFORMANT: Mrs Louise Heights ADDRESS 1207 S. Hanover Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage

DUE TO

(B) Incised wounds Neck

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] ~~CAUSE OF~~ DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1810 Park Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 3 11 49 ? m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Sharp instrument

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: Paul L Boyer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]
23C. DATE SIGNED: March 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Mar 14 49
24C. NAME OF CEMETERY OR CREMATORY: Murphy N. Co
24D. LOCATION (City, town, or county) (State): Murphy N. C

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE: Washington Millinery, Inc
25. FUNERAL DIRECTOR: Philip Henry Sons
ADDRESS: 2024 Eutaw St

VS 151

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G72348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50.10

G72348

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CARRIE MOSES.

2. DATE OF DEATH: 3/11/1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 6206 Park Heights Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 91 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 6206 Park Heights Ave. 2-7-20

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	6/14/1857.	91		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Jacob Stern

14. MOTHER'S MAIDEN NAME: Babette Fox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No	None	Mr. Daniel J. Moses, 6206 Park Heights Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Congestive heart failure — DUE TO

(C) Arteriosclerosis

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 1 week

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* November, 1947, *to* March, 1949 *that I last saw the deceased alive on* 11 Mar., 1949 *and that death occurred at* 5:15 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul Hamburger Jr. M. D.	1207 Eutaw Place	3/13/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/13/1949.	Hebrew Friendship	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 14 1949		Harris Levine & Son 1902 Eutaw Place.

VS 150

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G72349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

150.0 G72349 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BERTHA K. BLONDHEIM

2. DATE OF DEATH: 3/11/1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 936 Brooks Lane.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 84 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 936 Brooks Lane. 13 01

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widow	4/1/1864	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Joseph Kaufman

14. MOTHER'S MAIDEN NAME: Helena Stern

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	None	Mrs. Jesse S. Fleischer,	936 Brooks Lane.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myocardial failure	1 year
DUE TO	(B) Arteris-sclerosis	5 yrs
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1945, 19, *to* March 11, 1949, *that I last saw the deceased alive on* 3/11, 1949, *and that death occurred at* 7 30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Frederick Lentz M. D.	Temple Garden Apts.	3/12/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/13/1949.	Baltimore Hebrew	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 12 1949		David Sonnheim & Son 1902 Eutaw Place.

VS 150

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G72350

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E971-5 ✓ 52458

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Selma E Yaffey Or Yaffe — N. 965. 0

2. DATE OF DEATH March 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hosp

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3812 WoodHaven Ave — 15 — 38

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Baltimore Md	

13. FATHER'S NAME Louis Yaffe

14. MOTHER'S MAIDEN NAME Esther Krieger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Harry Yaffe	3812 WoodHaven Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Poisoning due to Ingestion of Mercury — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	at home	3812 WoodHaven Ave

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
3 / 12 - 49 - 9 a m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Swallowed tablets of Bichloride of Mercury

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
William L Helfrich M.D.		3/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 13/49	Windsor Mill Rd Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
APR 1 1949	[illegible] for Williams, M.D.	Sol Levinson & Bros	W. Northern

MAR 13 1949

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G72351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 1 80 Registered No. G72351

1. NAME OF DECEASED (Type or Print): Christian Brandau	2. DATE OF DEATH: March 11. 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 3105 N.Charles St.	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Marvland B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3105 N. Charles St.	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)	D. STREET ADDRESS (If rural, give location): 3105 N. Charles St. 12-07
5. SEX: Male	6. COLOR or RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: March 26.1872
9. AGE (In years last birthday): 76 yrs (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Contractor&Builder	10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore. Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Peter Brandau	14. MOTHER'S MAIDEN NAME: Dorothy E. Stratmeyer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs. Ruth Hobson.	ADDRESS: Salisbury. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of Kidney - mt. to	10 months
	DUE TO mt. tumors to liver & lungs	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: 6/26/48	19B. MAJOR FINDINGS OF OPERATION: Carcinoma - mt Kidney	20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): N	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/3/48, 19__, *to* 3/11/49, 19__, *that I last saw the deceased alive on* 3/10/49 19__, *and that death occurred at* 1.35A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Francis W Gluck M. D.	23B. ADDRESS: 3406 St. Paul St.	23C. DATE SIGNED: 3/11/49
24A. BURIAL, CREMATION, REMOVAL (Specify): Burial	24B. DATE: March 14,1949	24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore. Md.		
DATE RECEIVED BY LOCAL REGISTRAR: MAR 13 1949	REGISTRAR'S SIGNATURE: [illegible]	FUNERAL DIRECTOR: [illegible] ADDRESS: 4510 Liberty Hgts Ave.

MAR 13 1949

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G72352 ✓ X 4-20-1 G72352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Gertrude R. Frederick

2. DATE OF DEATH: 12 March 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3413 Childs Court

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3413 Child's Court

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hanover Township
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	White	Single	3/25/1875	73	11	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Mathew

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT: Family - Same ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 12 March 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	3/15/49	Maple Hill	Hanover Township, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: James L. McCauley ADDRESS: 130 E. Fort Ave.

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G72353 ✓ BALTIMORE CITY HEALTH DEPARTMENT 260 G72353

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JEANNE ABRAMSON

2. DATE OF DEATH: 3-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hutzlers Garage
c. Length of stay in Baltimore: 20 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3411 Bancroft Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	1904	45		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		New York NY	

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Olgd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Nathan Abramson	3411 Bancroft Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute Coronary Thrombosis	1/2 hr.
DUE TO (B)	Diabetes Mellitus	10 yrs.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1937 *to* Mar 11, 1949, *that I last saw the deceased alive on* Mar 11, 1949, *and that death occurred at* 11:20 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Elkes N Hunelpark M. D.	1801 Eutaw Pl	3/12/49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	3-13-49	Hebrew Friendship	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 13 1949	Thornton Williams M.D.	Jack Lowe Inc	2100 Eutaw Place

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G72354 ✓ G72354 54

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1120

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): JOSHUA APPLESTEIN
2. DATE OF DEATH: 3-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2800 Springhill Ave
c. Length of stay in Baltimore: 44 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15
D. STREET ADDRESS (If rural, give location): 2800 Springhill Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married		66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Window Trimer		Latvia	

13. FATHER'S NAME: Louis
14. MOTHER'S MAIDEN NAME: Fannie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Dora Applestein	2800 Springhill Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypertension	?
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)	Coronary occlusion	2 weeks
DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 2, 1949, *to* March 12, 1949, *that I last saw the deceased alive on* 3/12, 1949, *and that death occurred at* 5:45 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank Levinson M.D.	708 W Lafayette Ave	3/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-13-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
APR 1 1949	[illegible]	Jack Lewis Inc	2100 Eutaw Pl

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G72355 BALTIMORE CITY HEALTH DEPARTMENT G72355

CERTIFICATE OF DEATH

BIRTH NO. 4201 Registered No.

1. NAME OF DECEASED (Type or Print): HESTER-E-ARMACOST

2. DATE OF DEATH: MARCH 12-49

3. PLACE OF DEATH: a. Baltimore City, Maryland 2967 Kenneth Rd

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

c. Length of stay in Baltimore: 2 weeks (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Mayland B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Trenton
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Married	Jan 25/1871	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mayland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Julius M Bond
14. MOTHER'S MAIDEN NAME: Elizabeth A Painter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Harvey S Armacost ADDRESS: Upperco Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary thrombosis — Interval between onset and death: 12 hours
DUE TO
(B) Arteriosclerosis — 10 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* MARCH 5, 1949, *to* MARCH 12, 1949, *that I last saw the deceased alive on* MARCH 12, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Arthur J Davis M. D.
23b. ADDRESS: 800 W 33rd St
23c. DATE SIGNED: 3-12-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Mar 15/49
24c. NAME OF CEMETERY OR CREMATORY: Grave Run
24d. LOCATION (City, town, or county) (State): Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 1 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: Edw Tipton ADDRESS: Hampstead Md

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rebecca Belle Brooks

2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Haven Nursing Home 4515 Garrison Blvd

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: City
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2417 N. Calvert Street 1203

5. SEX: Female
6. COLOR or RACE: White
7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 3-9-1867
9 AGE (In years last birthday): 82 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.): 0 2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired school Teacher
10B. KIND OF BUSINESS OR INDUSTRY: Balto: Public School
11 BIRTHPLACE (State or foreign country): Baltimore, Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Brooks
14 MOTHER'S MAIDEN NAME: Elizabeth Crawford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17 INFORMANT: Mrs. Isabelle Meredith
ADDRESS: 804 E. North Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
Age

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar 1 1949 *to* Mar 11 1949 *that I last saw the deceased alive on* Mar 9 1949 *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: William H Bean M.D.
23B ADDRESS: 105 N. Charles St
23C DATE SIGNED: Mar 12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-14-49
24C NAME OF CEMETERY OR CREMATORY: Lorraine Cemetery
24D LOCATION (City, town, or county) (State): 5606 Dogwood Road, Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 13 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: George J. Ruth, Inc.
ADDRESS: 1735 Harford Avenue

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Emma Pearce

2. DATE OF DEATH: 3/10/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Z. M. H.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lemuin Memorial Hospital

C. Length of stay in Baltimore: 53 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 13-08
D. STREET ADDRESS (If rural, give location): 1222 N. 36 St. St. Balt.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	Under 1 Year: Months, Days	If Under 24 hours: Hours, Min.
F	Wh	M W D	April 13, 1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H. W.	—	Maryland	U. S. A.

13. FATHER'S NAME: John Miller

14. MOTHER'S MAIDEN NAME: Kate Meyers.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	?	Daughter	?

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease

DUE TO

(B) Acute Pulmonary Edema

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-10, 1949, *to* 3-10, 1949 *that I last saw the deceased alive on* 3-10, 1949 *and that death occurred at* 7:15 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James McC. Finney M. D.	Lemuin Memorial Hospital	3-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Mar 14/49	Waugh Chapel	Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Tunstin Williams, M.D.	Tunstin E. Donovan	3638 Roland Ave

937

AB-126983

G72358

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72358

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Enoch Mae Brady

2. DATE OF DEATH: March 11-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1309 N. Chapel St.

8 07

E. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Female	Negro	Single	Feb. 25- 1935	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.

13. FATHER'S NAME: William Brady

14. MOTHER'S MAIDEN NAME: Hazel Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Baltimore City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Congestive heart failure	2 yrs.
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Rheumatic fever	8yrs.
DUE TO	Rheumatic heart disease, active, with mitral insufficiency and stenosis, myocarditis, pericarditis, and pulmonary edema. XXXX	8yrs.
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES XX NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 18- , 1949, *to* March 11- , 1949, *that I last saw the deceased alive on* March 11 1949, *and that death occurred at* 6.15AM, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	Baltimore City Hospitals	March 12-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Mar 24-1949	Mt Calvary Cemetery	A. A. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 13 1949	[signature]	Robert B. Williams	1515 McElderry St

VS 150

58 B

Dr 17 Y G72359 ✓ G72358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

597 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sarah E. Tuckyer

2. DATE OF DEATH: March 8-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1222 E. Biddle St

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 1222 E. Biddle St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 10-01
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	C	married	1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	—	Virginia	U.S.A.

13. MOTHER'S NAME	14. MOTHER'S MAIDEN NAME
Ethrum Bolden	Ella

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Virginia Brown	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	10 days
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Marked Hypertension	Complex
DUE TO		
(C)	Chronic Nephritis	Complex
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Mitral Insufficiency & Diabetes	Complex

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Feb 27 1949 *to* March 8, 1949 *that I last saw the deceased alive on* March 7, 1949, *and that death occurred at* 8:15 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ralph L. Vannus M. D.	1429 E. Monument St	3/02/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	3/13/49	Mt Calvary Cemetery	A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 1949	Custis Fox Williams, M.D.	R. Percy Williams	1515 McCulloh St

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4 copies

G72360 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72360 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hayes Hackley — 2. DATE OF DEATH: 3/11/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1411 E Madison St.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE — B. COUNTY — 1411 E Madison St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — 10-07

D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	married	March	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Va	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Hackley	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	216-09-2531	Siggie Hackley	1411 E Med St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension — 2 yrs

DUE TO

(C) Diabetes Mellitus — 10 yrs

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hem Arteriosclerosis — 2 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-12, 1947 *to* 3-11, 1949 *that I last saw the deceased alive on* March 10, 1949, *and that death occurred at* 1:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. W. McDaniel M. D.	507 N Caroline St	3-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	March 15 1949	Mt Calvary Cemetery	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 1 3 1949	for Jos. Williams, M.D.	Robert Williams	1515 McElderry St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G72561 — Registered No. 4/20/1 G72561

1. NAME OF DECEASED (Type or Print): Gordon Norris
2. DATE OF DEATH: 9 Mar. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2023 E. Baltimore St.
C. Length of stay in Baltimore: Life. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 2023 E. Baltimore St. 2-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White		April 4 1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur, Balto Transit Co
10B. KIND OF BUSINESS OR INDUSTRY: Balto Transit Co
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: J. Ward Norris
14. MOTHER'S MAIDEN NAME: Mabel Foreman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): First World War
16. SOCIAL SECURITY NO.: 216-01-2028
17. INFORMANT: (Wife) Katherine T. Norris — ADDRESS 2023 E. Baltimore St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	3 mos.
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Duodenal Ulcer	3 mos.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 9 Mar. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	3/12/49	U.S. National Cem.	Finderne care

DATE RECEIVED BY LOCAL REGISTRAR: MAR 31 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Wendell J. Rupp — ADDRESS 320 Highland Ave
1178

G72362 BALTIMORE CITY HEALTH DEPARTMENT 177 G72362

CERTIFICATE OF DEATH (CAULK)

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Charles Jacob Caulk — 2. DATE OF DEATH Mar. 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Wheeler Ave

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 35 Wheeler 20 0 +

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Widowed	Sept. 1, 1875	73	6 12 +	+

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinest	B. & O. R.R. Retired	Maryland	U. S. A.

13. FATHER'S NAME Jacob Caulk

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	None	None	Ellen J. Spriggs	35 Wheeler Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of prostate gland — 1 yr.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C) Senility. myocarditis

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 2-10, 1949, *to* 3/11, 1949, *that I last saw the deceased alive on* 3/10, 1949, *and that death occurred at* 3:35 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. P. Calas, M. D.	47 N. Fulton Ave.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar. 15, 1949	Loudon Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Justin Tom Williams	Geo. L. Schwab	2101 Frederick Ave.

VS 150

51B

#72363 CERTIFICATE CORRECTED 4-5-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. | 8 | Registered No. G72363

1. NAME OF DECEASED (Type or Print): CHARLES ELMER JAMISON

2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2530 Lauretta Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2530 ~~Loudon~~ Lauretta Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct 21, 1873
9. AGE (In years last birthday): 75 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal Clerk, retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles E. Jamison
14. MOTHER'S MAIDEN NAME: Ellen Ferguson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS: Mrs Elizabeth Sherman, 2530 Lauretta Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Carcinomatosis	6 mos.
DUE TO	carcinoma of bladder (primary)	2 yrs.
(B)		
DUE TO		
(C)		

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1947
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Bladder
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* Feb 15, 19[illegible] *to* [illegible], 1949, *that I last saw the deceased alive on* March 10, 1949, *and that death occurred at* 7:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M.D.
23B ADDRESS: [illegible]
23C DATE SIGNED: [illegible]

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/14/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR ADDRESS: William Cook, Inc., 1217 St. Paul St.

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G72364

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 Registered No. G72364

1. NAME OF DECEASED (Type or Print): WILLIAM RILEY BRINN, SR.

2. DATE OF DEATH: March 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland ~~803 Scott St.~~

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 803 Scott St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 803 Scott St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
Male	White	Married	May 4, 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Crane operator	Harry T. Campbell Co	North Carolina	

13. FATHER'S NAME: Jeptha Brinn

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-01-4148	Nellie C. Brinn	803 Scott St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis, right — 3 days
DUE TO
(B) Hypertensive Cardiovascular Disease — 4 years
DUE TO
(C) Arteriosclerosis — 5 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 9, 1946 *to* March 12, 1949, *that I last saw the deceased alive on* March 11, 1949, *and that death occurred at* 11:05 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John P. Ulrich Jr. M. D.	1227 Wash. Blvd	3-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/15/49	Meadow Ridge	Dorsey, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	[illegible]	William Cook, Inc.,	1217 St. Paul St.

VS 150

93D

G72365

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72365

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Elliott

2. DATE OF DEATH: 13 Mar. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 601 E. Chase St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 601 E. Chase St 16-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	10/22/1875	73	4 / 21	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	Self	Balto	

13. FATHER'S NAME: John A. Elliott

14. MOTHER'S MAIDEN NAME: Mary Cleary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arterio sclerotic Cardio-Vascular Disease	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Hammer Jr. M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: 13 Mar. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/16/49	Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	[illegible] for Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

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93D

G72366 ✓ 53 G72366

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Mary E. Koenig
2. DATE OF DEATH: 3/12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2017 Braddish Ave. # 17 — 15-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	W		77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	At Home	Baltimore Maryland	

13. FATHER'S NAME: Henry Smith
14. MOTHER'S MAIDEN NAME: ~~Christina E. Koenig~~ Mary Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		Christian E Koenig 2017 Braddish Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Colon
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
1/15/49	Carcinoma of Colon	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/15, 1949, *to* 3/12, 1949, *that I last saw the deceased alive on* 3/12, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Orlyn H. Wood M. D.	West Baltimore General Hosp.	3/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	3/16/49	Cedar Hill	U. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
MAR 14 1949	Emily [illegible] Williams, Jr.	Wm Cook Inc 217 St. Paul St.

VS 150

46 F.

G72567 ✓ 147 G72567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Weatherall Ellicott

2. DATE OF DEATH: 3-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1209 John Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Women's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Widowed	12-12-63	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	Self	Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Isaac Thompson	Annie Weatherill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Francis S. Silver	Darlington Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular accident

DUE TO

(B) Hypertensive Vascular Disease

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-12-49, 19, *to* 3-13-49, 19, *that I last saw the deceased alive on* 3-12-49 19, *and that death occurred at* 5:45A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. C. Deetken M.D.	Women's Hospital	3-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/15/49	Green Mount	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Registrar of Vitals	Wm Cook Inc.	1217 St. Paul St.

VS 150

93D

G72508 ✓ G72508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Barghorn, Lena Louise

2. DATE OF DEATH: Mar. 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for the Women of Maryland

c. Length of stay in Baltimore: 58 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2424 N. Calvert St 12 03

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: July 24 1890
9. AGE (In years last birthday): 58 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Lawrence Ausberger
14. MOTHER'S MAIDEN NAME: Marie Vactie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Patient
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism — Interval between onset and death: Immediate

DUE TO

(B) Auricular fibrillation — Interval between onset and death: ?

DUE TO

(C) Arteriosclerotic heart disease — Interval between onset and death: ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

19A. DATE OF OPERATION: March 8, 1949
19B. MAJOR FINDINGS OF OPERATION: Embolus in brachial artery left
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): -
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): -
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): -

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: - m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR? -

22. *I hereby certify that I attended the deceased from* March 8 1949 *to* March 12 1949, *that I last saw the deceased alive on* March 12 1949, *and that death occurred at* 1:12 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ebert T. Bennet M. D.
23B. ADDRESS: Hosp for Women of Md.
23C DATE SIGNED: Mar. 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/15/49
24C NAME OF CEMETERY OR CREMATORY: London Park
24D LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams
25 FUNERAL DIRECTOR: Wm Cook Inc.
ADDRESS: 1217 St. Paul st.

VS 150

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G72569 ✓ G72569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

190 Registered No.

BIRTH NO. BC-48-16758

1. NAME OF DECEASED (Type or Print) Linda K. Tippie

2. DATE OF DEATH 3/12-49

3. PLACE OF DEATH
A. Baltimore City, Maryland 1909 Linden Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Md. Gen'l Hospital

c. Length of stay in Baltimore Yrs. Mos. Days 1 6

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md.
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 1909 Linden Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	W	Single	Aug 7th 1948		7 5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto. Md.	✓

13. FATHER'S NAME Robert Tippie

14. MOTHER'S MAIDEN NAME Evelyn Duff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mrs. Robert Tippie 1909 Linden Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/10 to 3/12, 19 49, *that I last saw the deceased alive on* 3/11, 19 49, *and that death occurred at* 1:25 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ed Zimmerman M. D.	2935 Harford Rd	3/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/15/49	Prospect Hill - Towson	Towson Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 14 1949	Evelyn Williams	Wm Cook Inc. 217 St. Paul St

VS 150

108

G72570 ✓ X

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

49 Registered No. G72570

BIRTH NO. BG-49-02584

1. NAME OF DECEASED (Type or Print): Darleen M. Litchfield
2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Halethorpe
D. STREET ADDRESS (If rural, give location): 1819 Winans Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	2/6/49		1 / 5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto. Md.	

13. FATHER'S NAME: John R. Litchfield Jr.
14. MOTHER'S MAIDEN NAME: Thelma C. Merk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		John R. Litchfield 1819 Winans Ave Halethorpe

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO
(B) Aspiration
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 11 1949 *to* March 11, 1949 *that I last saw the deceased alive on* March 11, 1949, *and that death occurred at* 12 15 Pm., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. Shohler M. D.	Bon Secours Hosp.	3/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/14/49	Glen Haven	Glenburnie A.A.C. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	[illegible] for Williams	Wm Cook Inc.	127 St. Paul St

VS 150

Franklin 8080 107

G72371

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 21 G72371

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Ethel V. Baughman

2. DATE OF DEATH: March 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1709 Sulgrave Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1709 Sulgrave Avenue 27-15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
female	white	married	?	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME: ?

14 MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
			Mrs. Mary Ford	1709 Sulgrave Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Death Sudden

DUE TO

(B) Hypertension

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-25 19 48 *to* March 12 19 49, *that I last saw the deceased alive on* March 10 19 49 *and that death occurred at* 9:35 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C DATE SIGNED
Samuel H. Culley Jr. M. D.	5611 Reisterstown Rd	3-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
burial	3/14/49	Lorraine Cemetery	Woodlawn, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	[illegible]	Wm. Cook, Inc.,	1217 St. Paul Street

OS 150

83a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 983.8

S72.1.72

S72.1.72

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BERNARD ANDERSON N-990

2. DATE OF DEATH February 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1103 Bentalou Street 16-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
male	white		?	30				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		?	

13. FATHER'S NAME
Unknown

14. MOTHER'S MAIDEN NAME
Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Drowning
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS ~~HOMICIDAL~~ OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Harbor	Foot of Bond Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Feb. 15, 1949 10:?5 p.m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Fell overboard during altercation

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George L. Merrill M.D.	[X]	Feb. 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	MAR 7 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 14 1949	Hunter for Williams, M.D.	Commissioner of Health

VS 151

168

G72573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

174 Registered No. G72573

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Dora L.Legen

2. DATE OF DEATH 3/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 137 McPhail St.

C. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 137 McPhail St. 20-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	White	Married	March 22,1888	60				

10A. USUAL OCCUPATION (Give kind of work, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H.W.	none	Balto.Md.	

13. FATHER'S NAME Frederick Carle

14. MOTHER'S MAIDEN NAME Annie Stumpf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Husband ADDRESS Joseph H. Legen ,137 McPhail St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma Uterus — 1 yr.

DUE TO

(C) Metastasis. — 3 mo.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr 2, 19 49 *to* March 10, 19 49 *that I last saw the deceased alive on* March 9, 19 49 *and that death occurred at* 10 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. Curtis Q., M.D.	1933 W. Fred. St	3/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/14/49	Loudon Park	3801 FrederickRd.Balto.Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Huntington Williams M.D.	Harry F. Mitchell	4101 Edmondson Ave.

VS 150

48 B

G72574

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72574

1. NAME OF DECEASED (Type or Print)	ANNIE DUTTON	2. DATE OF DEATH	March 11, 1949
3. PLACE OF DEATH: A.	Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	Provident Hospital	B. COUNTY	
		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)	Baltimore
c. Length of stay in Baltimore	Yrs. Mos. Days	D. STREET ADDRESS (If rural, give location)	162 Dolphin Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	Colored		January 5, 1873	76 mt		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Dept of Public Welfare	Baltimore City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Ins. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	M.D.	23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
Earle Ryan			3-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/14/49	Mt Auburn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Huntington Williams, M.D.	Charles P. Law	802 Madison Ave

VS 151

937

G72375 ✓ X G72375

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4/20

Registered No.

1. NAME OF DECEASED (Type or Print): Wm. W. Duncan.

2. DATE OF DEATH: 3-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: 15 Yrs 4 Mos Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence prior to admission)
A. STATE: 37 Emory ave.
B. COUNTY: Balt
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Catonsville
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Sept 27, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	U.S. army	Tenn	

13. FATHER'S NAME: James C Duncan

14. MOTHER'S MAIDEN NAME: Mary Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes		Mrs Mary Duncan	37 Emory Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Occlusion	2 hrs.
DUE TO (B)	Arteriosclerosis	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Mar 12, 1949 *to* March 12 1949 *that I last saw the deceased alive on* March 12 1949 *and that death occurred at* 9:51 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James P. Magee M. D.	336 Medford Av	3/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/16/49	Balto. National	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Emilie for Williams, Jr.	Harry H. Wright	

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G72376

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

19 D

Registered No. G72376

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELIZABETH LEVIN

2. DATE OF DEATH 3-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTO.

c. Length of stay in Baltimore 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28 W
D. STREET ADDRESS (If rural, give location) 4009 Aragow Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	M		32		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		New Berne N.C	

13. FATHER'S NAME Jonas Levinson

14. MOTHER'S MAIDEN NAME Fannie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Samuel Leon 4009 Aragow Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Melanocarcinoma with metastasis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Feb. 22, 19 49 to Mar 12, 19 49 that I last saw the deceased alive on Mar 12, 19 49 and that death occurred at 5:35 P m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Irvin W. Lueknor M. D.	Sinai Hospital of Baltimore	3-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-14-49	Beth T Jacob	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Thurlington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

55E

G72577 G72577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47-1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George T. Bramble
2. DATE OF DEATH: March 11-1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 17 2 W. Pratt St
c. Length of stay in Baltimore: 45 years (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 17 2 W. Pratt St 19 ward

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Jan 19. 1865	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kent Co Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John T. Bramble
14. MOTHER'S MAIDEN NAME: Henrietta Hastly
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sarah E. Bramble ADDRESS: 17 2 W. Pratt St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 4 years

DUE TO

(B) Arter. & Senil — 4 years

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/9/49, 19__, *to* 3/11/49, 19__, *that I last saw the deceased alive on* 3/9/49, 19__, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Hala F Bowen, M. D.
23B. ADDRESS: 4012 Edmondson
23C. DATE SIGNED: 3/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 14-1949
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: 3/14/1949
REGISTRAR'S SIGNATURE: [illegible] for Williams M.D.
25. FUNERAL DIRECTOR: Roth & B. M. Walter ADDRESS: Pratt & Stricker St

FS 150

93D

G72578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72578

BIRTH NO. B.C. 49-03329

1. NAME OF DECEASED (Type or Print): BABY JACKSON

2. DATE OF DEATH: February 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 616 Baker Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 616 Baker Street 15-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
?	colored		?			5 / 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		?	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Mrs. Frances Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
		Mrs. Lottie Johnson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George G. Merrill M.D.	☐ / ☒ / ☐	Feb. 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	MAR 7 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
MAR 14 1949	Huntington Williams, M.D.	Commissioner of Health

VS 151

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AB-126692

G72379

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

585

G72379

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Gus Adams

2. DATE OF DEATH March 6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 623 W. Baltimore St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Single	Feb. 3- 1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.

13. FATHER'S NAME: William Adams

14. MOTHER'S MAIDEN NAME: Mary Constantine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records	Baltimore City Hospitals 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hepato-renal Syndrome	6days
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Broncho-pneumonia	6days
DUE TO		
	(C) Cholecystitis	?
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Cirrhosis of liver	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 7- 1949, *to* March 6 1949, *that I last saw the deceased alive on* March 6 1949, *and that death occurred at* 8.50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	Baltimore City Hospitals	March 12-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/14/49	Sacred Heart	Lyman Hill Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Hunter for Williams, M.D.	John J. Fahey	Towson

Vs 150

124B

G72380

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72380

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE FLEMING

2. DATE OF DEATH March 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1309 Greenmount Avenue 9 & 9

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
male	white	Single	Aug 12th 1890	58 58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter		England	England

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mr Penland	1309 Greenmount ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lueic Constitution — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Royer		March 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 14th 1949	St Matthews	O'Donnell St Est

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Cynthia Lee Williams, Jr.	Leo G. Brock	1701-05 N. Patterson Park ave

VS 151

307

672381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. E 8 17 4 Registered No. 672381

1. NAME OF DECEASED (Type or Print): JOSEPH KUCHARCZYK or KUHARCZYK (JOSEPH KUBICYK) N- 8 x 8.2

2. DATE OF DEATH: March 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1803 Fleet Street 2-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Married	3-15-1901	47				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stevedore		Lubin Russia	Naturalized

13. FATHER'S NAME: Anthony Kucharczyk
14. MOTHER'S MAIDEN NAME: France Reputakowski April 2, 1922

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	World War I	215-09-7426	Josephine Kucharczyk	2350 Foster Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) Rupture of aorta, with massive hemorrhage into left chest cavity

DUE TO

(b) Fractured ribs

DUE TO

(c) Fractured right radius and ulna

(d) Fractured right femur

(e) Fractured right tibia and fibula.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Fait & Luzerne Avenues
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: March 12, 1949 2:15 Am.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 3-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 15, 1949	Holy Rosary	Baltimore County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE: Emma Jean Williams, M.D.
25. FUNERAL DIRECTOR: George A. Weber ADDRESS: 705 South Ann St.

VS 151

170c

G72382 ✓ X G72382

443

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY Balto CITY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE md COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville — LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1303 N. Fremont ave	STREET ADDRESS (If rural give location) 1110 St Agnes Lane

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Etta V. Williams	Feb. 9. 1949

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
F	C	Married	aug 15 1893	55 yrs.				

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home wife		md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Budd	Rebecca Powell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
		James Williams

18. MEDICAL CERTIFICATION

DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Cardiac Failure (due to exertion)

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Mitral Insufficient

(c) Hypertensive Cardiac Disease

INTERVAL BETWEEN ONSET AND DEATH: (a) 30 minutes (b) ? (c) ?

OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from 1-2-, 1949, to 2-9-, 1949, that I last saw the deceased alive on 2-9-, 1949, and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Edw Maloney MD	57 Winterbourne Balto 2 Md	2/9/49

BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/14/49	Western Star Cem	md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/14/49	Edw Maloney	Gray D. Nelson	1363 Presstman St

MAR 14 1949 County of Baltimore, Md.

G72383 ✓X G72383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57.1 Registered No.

BIRTH NO. B.C. 49-003069

1. NAME OF DECEASED (Type or Print): Baby Girl Altvater

2. DATE OF DEATH: March 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY: Baltimore
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Sparrows Point
D STREET ADDRESS (If rural, give location): 3119 Grace Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	March 8, 1949			1 / 14

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME: Robert Frances Altvater

14. MOTHER'S MAIDEN NAME: Margaret Catherine Altvater

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Margaret Catherine Altvater -- Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hydrops Foetalis

DUE TO

(B) Polycystic kidney, Left

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 8, 1949 *to* March 8, 1949, *that I last saw the deceased alive on* March 8, 1949 *and that death occurred at* 10:10 P. *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Ben G. Ray M. D	601 North Broadway	1-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
		Hebrew Benevolent	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 1 4 1949	Emma for Williams, M.D.		

MAR 14 1949

161 c

Hospital
Asphyxia Disposal

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-05337 — Registered No. 772384

1. NAME OF DECEASED (Type or Print): Baby "Boy" Phelps
2. DATE OF DEATH: MAR 10 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. — Mos. — Days 2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Overlea
D. STREET ADDRESS (If rural, give location): 103 E. Overlea Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White		3/8/49			2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant		Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Francis Phelps	Doris Mundy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—			JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxia — DUE TO

ANTECEDENT CAUSES

(B) Aspiration of amniotic fluid — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) premat. multiple birth

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-8- 1949 *to* 3-10 1949, *that I last saw the deceased alive on* 3-10 1949, *and that death occurred at* 2 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Hosp. Disposal	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Lucille for Williams, M.D.		

VS 150

160c

Hospital Disposal

G72385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

760.5

Registered No. G72385

BIRTH NO. B.C. 49-5275

1. NAME OF DECEASED (Type or Print): Baby Girl Robinson

2. DATE OF DEATH: March 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2002 S Bank Court

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Child	3-6-49			11

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Mary Rosa Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-6 1949 *to* 3-6 1949, *that I last saw the deceased alive on* 3-6 1949 *and that death occurred at* 9:20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: P Hauser, M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: Hosp Disposal

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949

REGISTRAR'S SIGNATURE: Curtis for Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS

VS 150

1602

G72586 443 ✓ G72586

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47 214 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HENRY WILLIAM HERTSCH
2. DATE OF DEATH: March 13 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mrs. Lewis Nursing Home 423 Springdale Ave. Baltimore 7, Md.
c. Length of stay in Baltimore: Thirty (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Woodlawn
d. STREET ADDRESS (If rural, give location): 1909 Belmont Terrace

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Widowed	June 17 1884	64	8	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10B. KIND OF BUSINESS OR INDUSTRY: Baltimore Transit Company
11. BIRTHPLACE (State or foreign country): Maryland (Balto.)
12. CITIZEN OF WHAT COUNTRY: United States
13. FATHER'S NAME: Charles Hertsch
14. MOTHER'S MAIDEN NAME: Emma Caroline Rau
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 213-10-0046
17. INFORMANT: Charles E. Hertsch 1909A Belmont Terr. Woodlawn, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE	5 years
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) DIABETES MELLITUS	4 months
	DUE TO (C) HYPERTENSIVE DISEASE	2 years
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Syphilis, primary	8 months

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 14 1948, to March 12, 1949 that I last saw the deceased alive on March 12, 1949, and that death occurred at 1:30 A m., from the causes and on the date stated above.

23A. SIGNATURE: Millard T. Trabold Jr M. D.
23B. ADDRESS: 3400 Woodbine Ave. Balto 7 Md
23C. DATE SIGNED: 3/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/16/49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

309

G72387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72387

BIRTH NO. G72387

1. NAME OF DECEASED (Type or Print): L. HARBURT STRAN

2. DATE OF DEATH: 3/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 514 E. 41st St.

C. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 514 E. 41st St. 9-01

5. SEX: male
6. COLOR or RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Apr. 13, 1890
9. AGE (In years last birthday): 58 yrs. (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto., Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Henry P. Stran
14. MOTHER'S MAIDEN NAME: Alberta Rictor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Grace H. Stran ADDRESS: 514 E. 41st St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Inspection-Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: John R Beers M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 3/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/15/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE: Catherine Jon Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 151

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G72388

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No. G72388

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MISS NAOMI ELIZABETH CLARY
2. DATE OF DEATH: 13 MARCH 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 906 NORTH CHARLES ST. #1

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 11 MAY 1891
9. AGE (In years last birthday): 57
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DRESS MAKER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): CARROLL COUNTY MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN D. CLARY
14. MOTHER'S MAIDEN NAME: IDA May STORMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: SISTER MARGARET CLARY ADDRESS: 3110 VIRGINIA AVE BALTIMORE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CEREBRAL HEMORRHAGE WITH LEFT HEMIPLEGIA	6 DAYS
DUE TO (B)	HYPERTENSIVE CARDIOVASCULAR DISEASE	10 YRS?
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	1) SPASTIC DEFORMITY of LOWER EXTREMITIES 2) HYPERTROPHIC DEGENERATIVE OSTEOARTHRITIS	SOME

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☒ REFUSED

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 MARCH, 1949, *to* 13 MARCH, 1949, *that I last saw the deceased alive on* 13 MARCH 1949, *and that death occurred at* 5:10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Donald L. England M. D.
23B ADDRESS: MARYLAND GEN. HOSP.
23C DATE SIGNED: 13 MAR 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/16/49
24C. NAME OF CEMETERY OR CREMATORY: Leisters Cem.
24D LOCATION (City, town, or county) (State): Carroll Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

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G72389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72389

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES F. BIEMILLER	2. DATE OF DEATH March 12, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3601 Clifton Ave.	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
c. Length of stay in Baltimore Yrs. Mos. Days	D STREET ADDRESS (If rural, give location) 3601 Clifton Ave. 15 46

5. SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
male	white	married	May 7, 1876	72 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Clerk - retired	B. & O. R. R.	Baltimore, Md.	

13. FATHER S NAME	14 MOTHER S MAIDEN NAME
John H. Biemiller	Caroline M. Preisz

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
no		Mrs. Mary R. Biemiller	3601 CliftonAv

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Inoperable carcinoma of prostate and abdominal viscera

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Myocarditis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

? from History about 4 Mo.

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 12 *1949, to* March 12 *1949 that I last saw the deceased alive on* March 12, 1949 *and that death occurred at* 12 30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Walter S Willett M. D.	2220 Harrison Blvd	March 13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/15/49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Custis Hillman	WM. J. TICKNER & SONS	Balto., Md.

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G72390

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No. G72390

BIRTH NO.

1. NAME OF DECEASED (Type or Print): St Luke Chen ,or Chen St Luke

2. DATE OF DEATH: March 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 50 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 322 Park Ave.

5. SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	Chinese	Single	Aug. 16, 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
—	—	Calif.	?

13. FATHER'S NAME: Henry Chen

14 MOTHER'S MAIDEN NAME: Irene ?

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No	No	NONE		Balto. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pulmonary infarction, due to embolus	24hrs.
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Hypertensive-arteriosclerotic heart disease with failure	10yrs. plus.
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Old hemiplegia, left	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 3, 19 49 *to* March 12, 19 49 *that I last saw the deceased alive on* March 12, 19 49 *and that death occurred at* 2.15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Fred S. Hoseo M. D.	4940 Eastern Ave.	3-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-14-49	Lorraine	Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	[illegible]	Stewart Mortuary Balto.	

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G72391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72391 Registered No. 44

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dorothea Royston

2. DATE OF DEATH: March-11-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland at home

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1833 N. Duncan Street

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1833 N. Duncan Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	May-6-1887	61-10-5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Baltimore, Md.	U. S. A.

13. FATHER'S NAME: Howard G. Delcher

14. MOTHER'S MAIDEN NAME: Sophia Baurentheis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	None		Mr. Clifton A. Royston (son)	545 Wellesley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 5, 1949, *to* March 11, 1949, *that I last saw the deceased alive on* March 11, 1949, *and that death occurred at* 9:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert Rosenberg, M. D.	2025 E. North Ave	March 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March-15-1949	Parkwood	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	[illegible]	Stewart & Mowen Company,	108 W. North Ave.

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G72392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450.0

G72392 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles E. MacIntire

2. DATE OF DEATH: March 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 4904 Fait Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 4904 Fait Ave. B. COUNTY 76 05
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) Maryland

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	White	Widowed	June 27 1875	73	7	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Bed. Steel Co.	Baltimore	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Charles E. MacIntyre	4904 Fait Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Chronic General Arteriosclerosis	12 & 15 yrs
DUE TO (B)	Cerebral Hemorrhage about	1938
DUE TO	Cataracts on both Eyes	4 yrs
(C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 6 1942 *to* Mch 12, 1949 *that I last saw the deceased alive on* Feb 28, 1949, *and that death occurred at* 6 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. D. Keown M. D.	1938 Linden Ave	3/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 15/49	St Matthews	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Thurston Williams, M.D.	Welsh Funeral Home	2008 Calvert St

VS 150

83a

TO BE APPROVED BY MEDICAL EXAMINER ✓

G72393 (Birth No.)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E903.0

G72393 Registered No.

1. NAME OF DECEASED (Type or Print): ALLEIN W. BATES — N-Div. 1

2. DATE OF DEATH: 3/12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: MARYLAND
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 18
D STREET ADDRESS (If rural, give location): GILMAN APTS.-APT. E-1 CALVERT & 31st

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: Yrs. — Mos. — Days —

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
FEMALE	WHITE	[redacted] WIDOWED	3/7/1853	96		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	—	CAMBRIDGE MARYLAND	UNITED STATES

13. FATHER'S NAME: CHARLES MITCHELL

14. MOTHER'S MAIDEN NAME: MARGARET ROACH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	—	HOSPITAL RECORDS	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

(B) FRACT. NECK RT. FEMUR / FRACT. NECK RT. HUMEROS — 13 days.

DUE TO

(C) ~~OLD AGE~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: OLD AGE

CERTIFICATION APPROVED BY

Chas. H. Kammer, M.D.

CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2/27/49	FRACT. NECK RT. FEMUR; FRACT. NECK RT. HUMERUS	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
ACCIDENT	HOME	HER ADDRESS AS ABOVE

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
2/27/49 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	FALL--slipped and fell to floor (Adm

22. I hereby certify that I attended the deceased from 2/23/49, 19__, to 3/12/49, 19__, that I last saw the deceased alive on 3/12/49 19__, and that death occurred at 3:00 P m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Dawson M.D.	UNION MEMORIAL HOSPITAL	3/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/15/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

186a

To be approved by Med Examiner.

G72394 E9160 G72394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): IRVIN T. BAKER N-948.

2. DATE OF DEATH: 12 March 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Gen'l Hosp
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY: Baltimore
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1507 E. 29th St. 907

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married.
8. DATE OF BIRTH: Oct. 23, 1899
9. AGE (In years last birthday): 49
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Invalid
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Lee Baker
14. MOTHER'S MAIDEN NAME: Emma M. Starr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Miss Lillian Baseman 1507 E. 29th. St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Irremible Shock.
DUE TO
(B) 1st, 2nd, 3rd degree burns of 85% of body surface
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Multiple Sclerosis

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
for: Wm. H. Hammer, Jr. M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1507 E. 29th St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 3 12 49 ? m.
21E INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F HOW DID INJURY OCCUR? Patient caught fire from ashes in cigarette or pipe

22. I hereby certify that I attended the deceased from 12 Mar, 1949, to 12 Mar, 1949, that I last saw the deceased alive on 12 Mar, 1949, and that death occurred at 3:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE: E. A. Cerasano M.D.
23B ADDRESS: Maryland Gen'l Hosp
23C DATE SIGNED: 3/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 3/15/49
24C NAME OF CEMETERY OR CREMATORY: Greenmount cemetery
24D LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE: Trustin for Williams, M.D.
25 FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND

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G72395

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-20-1 Registered No. G72395

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry Harms

2. DATE OF DEATH: 11 March 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2623 Eastern Ave.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2623 Eastern Avenue 1-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	Mar. 24, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tool- die maker	American Can Co.	Baltimore, Md.	USA

13. FATHER'S NAME: Carstens Harms

14. MOTHER'S MAIDEN NAME: Henrietta Dorjahn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	220-07-3097	Carstens C. Harms	Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 12 Mar. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	3/15/49	Mount Carmel	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25 FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.

ADDRESS: BALTIMORE - 13, MARYLAND

VS 151

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G72396

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

20-1

G72396

Registered No.

1. NAME OF DECEASED (Type or Print): John Gross

2. DATE OF DEATH: 3/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1923 Lauretta Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 923 Lauretta Ave. 20-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C		Dec. 7, 1883	65	3	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Night watchman	------	Baltimore, Md.	USA

13. FATHER'S NAME: Louis Gross

14. MOTHER'S MAIDEN NAME: Lucy Bundy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO: 215-01-6186

17. INFORMANT: Mrs. Estella Gross ADDRESS: 1922 Lauretta Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary arteriosclerosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: H. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 3/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/15/1949	Mt. Auburn	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: APR 1 1949

REGISTRAR'S SIGNATURE: Registrar for Baltimore, Md.

25. FUNERAL DIRECTOR: Wm. George H. Holland ADDRESS: Mount Hill Ave.

VS 151

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G72397

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72397

1. NAME OF DECEASED (Type or Print): Clarence Coates

2. DATE OF DEATH: 3-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp. Balto. Md.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 1705 Riggs Ave. 16-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	married	January 1 1886	63	1 / 1	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Laborer	Frederick Co. Md.	U.S.A.

13. FATHER'S NAME: Albert Coates

14. MOTHER'S MAIDEN NAME: Sydney Hayes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 215-01-2916

17. INFORMANT: Mrs. Virginia Coates ADDRESS: 1705 Riggs Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Probable Carcinomatosis with
DUE TO Incomplete Intestinal Obstruction 4-6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Also (1) Pos. liver & renal involvement → anuria
DUE TO

(C) (2) Diverticulosis of Colon
(3) Generalized Arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): None

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: None

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? None

22. *I hereby certify that I attended the deceased from* 3/1/49 19 *to* 3/10/49 19 *, that I last saw the deceased alive on* 3/9 *,* 1949 *, and that death occurred at* 6:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: J.B. Groth, M.D.

23B. ADDRESS: University Hosp. Balto. Md.

23C. DATE SIGNED: 3-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3/14/1949

24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Pk.

24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949

REGISTRAR'S SIGNATURE: Registrar for Baltimore, Md.

25. FUNERAL DIRECTOR: Jos. Carey H. Holland ADDRESS: 1111 Hill Ave.

VS 150 3-11-49

Post Mortem — Generalized Carcinomatosis — apparently from a primary Ca of the stomach. 46E

G72398

BALTIMORE CITY HEALTH DEPARTMENT 44

CERTIFICATE OF DEATH

Registered No. G72398

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Hill

2. DATE OF DEATH: MAR. 9. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland: BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 928 Mc Donogh St

c. Length of stay in Baltimore: 50 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D STREET ADDRESS (If rural, give location): 928 Mc Donogh St 7-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year, last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	Col	Widower	2.6.1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none.		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Alexander Hill	Catherine P

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No.	None.	Agnes Hill 928 Mc Donogh St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I (A)	Uremia — Pulmonary Congestion	2 days
DUE TO (B)	Chr. Cardio-Renal Vascular Disease	3-4 mos
DUE TO (C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3. 2. , 1949 *to* 3. 9 , 1949 *that I last saw the deceased alive on* 3. 9 , 1949 *and that death occurred at* 4 A. m., *from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. L. Burns M. D.	1420 E. Chase	3.12.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/14 49	Mt Calvary Fem	L. I Co.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 7 1949	Huntington Williams, M.D.	Cayser Sanders	1412 E. Preston St

VS 150

131a

G72399 G72399

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Rose M. Haiden
2. DATE OF DEATH: 3/13/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5 N. Catherine St.
C. Length of stay in Baltimore: 27 yrs (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5 N. Catherine St.
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 4/10/1899
9. AGE (In years last birthday): 49 (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Eder
14. MOTHER'S MAIDEN NAME: Rose Kroihs
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown): ✓
(If yes, give war or dates of service): ✓
16. SOCIAL SECURITY NO: ✓
17. INFORMANT: Mrs. May Haiden ADDRESS: 5 N. Catherine St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION — (Interval between onset and death): 4 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) EXOPHTHALMIC GOITER — 10 yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* APRIL 15, 1947 *to* 3/13, 1949, *that I last saw the deceased alive on* JAN. 23, 1949, *and that death occurred at* 1⁵⁰ *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: Gilbert E. Rudman, M. D.
23B. ADDRESS: 2517 W. Balto. St.
23C. DATE SIGNED: 3/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/16/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: MAR 4 1949
REGISTRAR'S SIGNATURE: Transcription from Milwaukee, Wisc.
25. FUNERAL DIRECTOR: John J. Cowan & Son ADDRESS: 919 Hollins St.

VS 150

63B

G72400 BALTIMORE CITY HEALTH DEPARTMENT 500 G72400

BIRTH NO. B.C. 48-2729 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) BEATRICE LILLIAN ADAMS

2. DATE OF DEATH March 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
300 Exeter Street

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 300 Exeter Street N. 5-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
female	colored	Single	Dec. 18/48		2	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME TYLER YOUNG
14. MOTHER'S MAIDEN NAME ARLINE NELSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tracheo-bronchitis, acute
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED March 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 3/14/49
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary
24D. LOCATION (City, town, or county) (State) Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 14 1949
REGISTRAR'S SIGNATURE Austin Lee Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS A. Halstead -918- Cedar Hill ave. 106

VS 151

G72401 G72401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Lena Pyatt

2. DATE OF DEATH 3-11-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. Wd. B. City

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 524-Saratoga St.

c. Length of stay in Baltimore Yrs. Mos. Days

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 402

D. STREET ADDRESS (If rural, give location) 524-Saratoga St.

5. [illegible] F. 6. COLOR OR RACE Col. 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow 8. DATE OF BIRTH Jan. 1905 9. AGE (In years. If under 1 year last birthday) 44 Months Days If under 24 hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed. 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Georgetown S.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Shaw 14. MOTHER'S MAIDEN NAME Sylvia Henry.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO

17. INFORMANT Richard Shaw ADDRESS 524-

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1 Day

DUE TO

(B) Pulmonary Congestion

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION None 19B. MAJOR FINDINGS OF OPERATION 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE? (Specify) No 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/20/49 19 , to 3/10 , 1949 *that I last saw the deceased alive on* 3/13 , 1949 *and that death occurred at* 708 *m., from the causes and on the date stated above.*

23A. SIGNATURE William Carney 23B. ADDRESS 213 Carey St 23C. DATE SIGNED 3/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried 24B. DATE 3/14/49 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. 24D. LOCATION (City, town, or county) Cedar Hill

DATE RECEIVED BY LOCAL REGISTRAR MAR 14 1949 REGISTRAR'S SIGNATURE Hunter Williams, M.D. 25. FUNERAL DIRECTOR A. Halstead ADDRESS 918-Druid Hill Ave.

VS 150

G72402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 90 G72402

Registered No.

BIRTH NO. B.C. 43-03870

1. NAME OF DECEASED (Type or print) Jonathan Gregory

2. DATE OF DEATH 3/12/49

3. PLACE OF DEATH: a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. State Md. B. County City.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 540 - W. Biddle St.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1741

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M.	Col.	Single	Feb. 7/49	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unemployed		Balto. Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Gregory	Delphine Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give branch and dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Frank Gregory	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 7 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/7 19 49 *to* 3/10 19 49, *that I last saw the deceased alive on* 3/10 19 49 *and that death occurred at* 11 3.0 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Wm Cooper M. D.	2123 Eutaw St	3/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town or County) (State)
Burial	3/15/49	Mt Calvary	Cedar Hill Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	[illegible] for Williams, M.D.	A. Halstead	918 - Druid Hill Ave. 108

VS 150

G72403

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72403

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH M. EUGENIA McLAUGHLIN

2. DATE OF DEATH: March 12, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland — St Vincents Home Orphanage

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Vincents Home Orphanage ~~Sister M. Eugenia McLaughlin~~

C. Length of stay in Baltimore: 39 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
STATE: York Road — COUNTY: Balto Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): York Road Balto Md.
D. STREET ADDRESS (If rural, give location): 6400 York Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months Days	If under 24 Hours: Hours Min.
FEMALE	WHITE	SINGLE	Feb. 25, 1883	66	1 7	— —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TEACHER	RELIGIOUS	Washington D.C.	

13. FATHER'S NAME: Charles McLaughlin

14. MOTHER'S MAIDEN NAME: Sarah Beatty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS (Street, City or Town, State)
NO			MOTHER BERNADETTE	PROVIDENCE Convent Mt. Washington Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CORONARY THROMBOSIS	5 minutes
DUE TO (B)	ARTERIOSCLEROTIC & HYPERTENSIVE CARDIO-VASCULAR DISEASE	18 years
DUE TO (C)	ANGINA PECTORIS	6 years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	DIABETES MELLITUS	12 years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
—		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 1939 *to* March 12, 1949 *that I last saw the deceased alive on* March 9, 1949 *and that death occurred at* 10:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Raymond Pettia M. D.	1127 N. Calvert St	3/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	3/15/49	Mt. St. Agnes	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949		H. W. Meaks & Son	505 N. Calvert St.

VS 150

61

72404

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159 G72404
Registered No.

1. NAME OF DECEASED (Type or Print) **Katie W. Becht**

2. DATE OF DEATH **3/12/49**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **21 S. Carey St.**
c. Length of stay in Baltimore **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **21 S. Carey St.** 1802

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	**White**	**Widowed**	**Jan. 26, 1860**	**89**				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H.W.	**None**	**Md.**	

13. FATHER'S NAME **Hoener**

14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Rev. P. G. Gabler,	**106 E/ 32nd st.**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gastric Carcinoma — DUE TO — (INTERVAL BETWEEN ONSET AND DEATH) ?

ANTECEDENT CAUSES
(B) — DUE TO —

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) Arteriosclerosis — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* **Mar 10**, 1949 *to* **Mar 12**, 1949 *that I last saw the deceased alive on* **Mar 12**, 1949, *and that death occurred at* **2 P** *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Carl P. Rostering M. D.	**1326 W Lombard St**	**Mar. 17. 1949**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**3/15/49**	**Western**	**Baltimore, Md.**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Huntington Williams, M.D.	**Harry A. Britt & Co**	**4101 Edmondson Ave**

MHD 150

46B

G72405 ✓ 696 G72405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-05716 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Heller

2. DATE OF DEATH: March 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1107 Ashburton St 16 07

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp

C. Length of stay in Baltimore: 34 Yrs. / Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months Days	If under 24 Hours: Hours Min.
Male	White	Single	3-14-49			25

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	—	Balto. Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Louis Heller	Mary Lena Matthews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mother	1102 Ashburton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Premature - Wt 2' 6½"

DUE TO

(B) Premature ruptures of Membranes

DUE TO

(C) Maternal Diabetes Mellitus, controlled by diet.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/14, 1949, to 3/14, 1949, *that I last saw the deceased alive on* 3/14, 1949, *and that death occurred at* 7²⁰ a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Feder M. D.	West Balto. Gen'l Hosp.	3/14/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B		Loudon Park Cem	3601 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949		John J. Conrad & Son.	

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G72406

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72406 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Itzoe, Harry Lee

2. DATE OF DEATH: 3-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH BALTIMORE GENERAL HOSPITAL

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2210 Mura St 8 4

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 22, 1885
9. AGE (In years last birthday): 63
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore - Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 248-10-5884
17. INFORMANT: Elizabeth B. Itzoe ADDRESS: 2210 Mura St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion
DUE TO
Hypertensive arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-9-, 1949, *to* 3-12-, 1949 *that I last saw the deceased alive on* 3-11-, 1949, *and that death occurred at* 12:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: William F. Haven, M. D.
23B ADDRESS: Sou. Balti Gen Hosp
23C DATE SIGNED: 3-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/15/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Howard N. Bright ADDRESS: 6009 Harford Road

VS 150

93D

G72407

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

451 Registered No.

G72407

1. NAME OF DECEASED (Type or Print): Edwin A. Lloyd

2. DATE OF DEATH: March 12th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3810 Pinewood Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 3810 Pinewood Ave.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
male	white	widower	Aug. 21st, 1864	84	6 / 19	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cabinet Maker		Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Edwin Lloyd

14. MOTHER'S MAIDEN NAME: Elizabeth Eldon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	219-07-1671	Mrs. Manie Tomlin	3810 Pinewood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	ANEURYSM OF ABDOMINAL AORTA	1 MONTH +
DUE TO (B)	ARTERIOSCLEROSIS	10 YRS +
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	SENILITY	—

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/30, 1938 *to* 3/12, 1949, *that I last saw the deceased alive on* 3/12, 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	6331 Belair Rd (6)	3/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	3/15/49	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	[signature]	Lassahn Funeral Home	7401 Belair Rd.

VS 150

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G72408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 G72408

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William R. Lambdin

2. DATE OF DEATH: Mar. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1802 E. Fayette St.

C. Length of stay in Baltimore: life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto. Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write NO and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 1802 E. Fayette St 604

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug. 14, 1874
9. AGE (In years last birthday): 74 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.): 7 0
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (State or foreign country): Balto. Md.
11. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Joseph Lambdin
14. MOTHER'S MAIDEN NAME: Margaret -----
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ---
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 216-03-4509
17. INFORMANT: Mrs. Jennie Nelson
ADDRESS: 1802 E. Fayette St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) Congestive Heart Failure — Interval between onset and death: 10 Hours.

DUE TO

(b) Cardio-Vascular Hypertension Disease — 9 years

DUE TO

Arteriosclerosis — 9 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 10, 1940 *to* March 14, 1949, *that I last saw the deceased alive on* March 13, 1949, *and that death occurred at* 2:15A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Michael J. Dausch M. D.
23B. ADDRESS: 1 W. Chesapeake Ave.
23C. DATE SIGNED: 3-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Mar. 17/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cem.
24D. LOCATION (City, town or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE:
23. FUNERAL DIRECTOR: Philip Henry Sons
ADDRESS: 2024 Orleans ST.

VS 150

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G72409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

490 Registered No. G72409

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elaine Ashe Tibbs

2. DATE OF DEATH: March 11, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland 802 S. Fremont ave
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 802 S. Fremont ave

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Married	November 17, 1925	23	3	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife		Baltimore Maryland	American

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Cleveland Pearson	Sallie Sorell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Sallie Ashe	802 S. Fremont ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 12 Days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Pregnant 5 mo. Dead

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/1 1949 *to* 3/11 1949 *that I last saw the deceased alive on* 3/11 1949 *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Traverse M. D.	124 W. Lee st	3/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March 17, 1949	Mount Auburn Cemetery	Baltimore City Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Permission for Williams, M.D.	Joseph A. Lisley	661 W. Baltimore St.

VS 150

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G72410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G72410

1. NAME OF DECEASED (Type or Print) Thos S Manning

2. DATE OF DEATH 3/13/49

3. PLACE OF DEATH: a. Baltimore City, Maryland Balto Md

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Home

c. Length of stay in Baltimore 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE b. COUNTY Tappahannock Va

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Tappahannock Va.

d. STREET ADDRESS (If rural, give location) Tappahannock Va.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Unknown	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Tappahannock Va	

13. FATHER'S NAME William S. Manning

14. MOTHER'S MAIDEN NAME Lucy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Lenora Young	1914 W Mosher St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: weeks

DUE TO

(B) Cardio Vascular — months

DUE TO

(C) Arteriosclerosis — years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 25 19 49 *to* 3/13/49 19 , *that I last saw the deceased alive on* 3/13/49 19 , *and that death occurred at* 2 11 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm T Sorrow M. D.	402 Edmonson	3/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 16/49	Tappahannock Cemetery	Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949		W. Brooks	1463 N. Carey St

VS 150

131a

G72411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72411

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): James W Smith

2. DATE OF DEATH: 3/12/49

3. PLACE OF DEATH: a. Baltimore City, Maryland — Balto City

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1816 Woodyear

c. Length of stay in Baltimore: 26 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 15-01
1816 Woodyear St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Cnty
D. STREET ADDRESS (If rural, give location): 1816 Woodyear St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Feb 15-1906	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur		Lancaster Co	U.S.A.

13. FATHER'S NAME: Robert Smith

14. MOTHER'S MAIDEN NAME: Lucille ,

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-01-1347

17. INFORMANT: Estelle Smith — ADDRESS: 1816 Woodyear St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) TB of Bladder - Ureter — INTERVAL BETWEEN ONSET AND DEATH: Jan 1949

DUE TO Kidney - Prostate

(B) Multiple Urethra Calculi — 3 Mo-49

DUE TO Pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. /

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* F & A 1944, *to* 3-9, 1949, *that I last saw the deceased alive on* 3-9, 1949, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M B Butler M. D.	2500 Div St	3/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/15/49	Mt Auburn	Balto Cnty

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Hunter for Williams, M.D.	William A Jackson	916 Lemmon Ave

VS 150

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G72412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72412

BIRTH NO.

1. NAME OF DECEASED (Type or Print)	Elenora (Nora) Belle Stauffer
2. DATE OF DEATH	March 13, 1949
3. PLACE OF DEATH: A.	Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	2417 Calverton Heights Ave.
c. Length of stay in Baltimore	30 Yrs.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	2417 Calverton Heights Ave. 16 05
5. SEX	Female
6. COLOR OR RACE	White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	Married
8. DATE OF BIRTH	August 23,1888
9. AGE (In years last birthday)	60
If under 1 year: Months / Days	
If under 24 hours: Hours / Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Housewife
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	Frederick County, Md.
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Tighlman McDade
14. MOTHER'S MAIDEN NAME	Ella Dutrow
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	No
16. SOCIAL SECURITY NO.	218-16-1487
17. INFORMANT ADDRESS	Mr. Charles Stauffer, 2417 Calverton Hgts Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerosis & Endocarditis	3 yrs
	DUE TO Chronic Interstitial Nephritis	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August, 1946 *to* March 13, 1949, *that I last saw the deceased alive on* March, 1949, *and that death occurred at* 1.15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE M.D.	23B. ADDRESS Medical Arts Bldg.	23C. DATE SIGNED
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE March 16,1949	24C. NAME OF CEMETERY OR CREMATORY Good Shepherd Cemetery
		24D. LOCATION (City, town, or county) (State) Ellicott City, Md.
DATE RECEIVED BY LOCAL REGISTRAR MAR 14 1949	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR Ellis Amoreau ADDRESS 4510 Liberty Hgts Ave.

VS 150

1310

G72413

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72413

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Bridget Hughes

2. DATE OF DEATH: 3-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland X

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jenkins Memorial Hospital

C. Length of stay in Baltimore: 74 yrs. (Yrs. / Mon. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY X 830 Warwick Road 16 05
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 29 Md.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	Widowed	4-25-1858	90 yrs.	10	43

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Housewife	Ireland	

13. FATHER'S NAME: Martin Phelan

14. MOTHER'S MAIDEN NAME: Mary Dugan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
—	—	Andrew J. Hughes	830 Warwick Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Congestive Failure	
DUE TO (B)	Arteriosclerotic C-V	
DUE TO (C)	Senile	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 6:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John H. Shaw M.D.	10 E. Lynn Lane	3/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3-17-49	New Cathedral	Old Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	Huntington Williams, M.D.	John C. Moran	3000 E. Baltimore St

93Y

G72414

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

450.0 G72414 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)	EDMUND F. KRONEBERGER
2. DATE OF DEATH	Mar. 12, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	2516 Harlem Ave.
c. Length of stay in Baltimore — Yrs. Mos. Days	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	2516 Harlem Ave.
5. SEX	Male
6. COLOR OR RACE	White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	Widowed
8. DATE OF BIRTH	Mar. 30, 1861
9. AGE (In years last birthday) If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.	87 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	retired
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	Virginia
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Charles H. Kroneberger
14. MOTHER'S MAIDEN NAME	Wilhelmina Doerr
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT	Mrs. Henry Ittner
ADDRESS	2516 Harlem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized arteriosclerosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-31-49 *to* 3-14-49, *that I last saw the deceased alive on* 3-14-49, *and that death occurred at* 7:20 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	Roy S. Gambill M. D.	
23B. ADDRESS	2703 Edmondson Ave	
23C. DATE SIGNED	3-14-49	
24A. BURIAL, CREMATION, REMOVAL (Specify)	Entombment	
24B. DATE	3/15/49	
24C. NAME OF CEMETERY OR CREMATORY	Lorraine Maus.	
24D. LOCATION (City, town, or county) (State)	Woodlawn, Md.	
DATE RECEIVED BY LOCAL REGISTRAR	MAR 14 1949	
REGISTRAR'S SIGNATURE		
25. FUNERAL DIRECTOR	WM. J. TICKNER & SONS	
ADDRESS	Balto., Md.	

VS 150

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G72415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH No. 44 Registered No. G72415

1. NAME OF DECEASED (Type or Print): Minna (Marcellia) Marsiglia
2. DATE OF DEATH: 3-12-49
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2601 Reisterstown Rd
c. Length of stay in Baltimore: Life — Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY Balto. 2601 Reisterstown Rd.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-04
D. STREET ADDRESS (If rural, give location): 2601 Reisterstown Rd
5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Sept. 28-1893
9. AGE (In years last birthday): 55 — If Under 1 Year: Months 5, Days 17 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Salvatore Liberto
14. MOTHER'S MAIDEN NAME: Sarah Barranco
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs Send D. Moore ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-Sclerotic Cardio-Vas-Cular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: Several Years.

DUE TO (B) Cardiac Decompensation Hypertrophy. Auricular Fibrillation — 4th March

DUE TO (C) Pyelonephritis with Nephrolithiasis. — Several Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Cerebral Thrombosis Right with left side weakness — Several Years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 1947 *to* 12 March 1949, *that I last saw the deceased alive on* 4 March 1949, *and that death occurred at* 4:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: W Kennedy Waller M.D.
23B. ADDRESS: 31 W Cathedral St
23C. DATE SIGNED: 14 March 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 15- 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Joseph Sause Sr 2013 Greenmount Ave 1310

VS 150

G72436 ✓ X G72436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 760 Registered No.

BIRTH NO.

1 NAME OF DECEASED (Type or Print) JOSEPH KRAUSS

2 DATE OF DEATH 3/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md B COUNTY Carl
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Elkton
D STREET ADDRESS (If rural, give location) E. High St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Oct 4, 1898	50	5 / 4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Oyster		Cloria, Md.	U.S.A

13. FATHER'S NAME Edward Krauss

14. MOTHER'S MAIDEN NAME Minnie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Gladys T. Krauss	Elkton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetic coma — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Diabetic Acidosis

DUE TO

(C) Diabetes Mellitus

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ✓ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/14, 1949, *to* 3/14, 1949, *that I last saw the deceased alive on* 3/14, 1949 *and that death occurred at* 1 P.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benson Schwartz M. D.	Sinai Hosp. - Balto.	3/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Mar. 14/1949	Elkton	Elkton Cecil Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 14 1949	[illegible]	H. W. Pippin & Son	Elkton Md.

Vs 150

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BIRTH NO. 127082 G72417 BALTIMORE CITY HEALTH DEPARTMENT G72417

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): William Dugger
2. DATE OF DEATH: 3- 13- 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 8 Years (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1603 Light ST 27-04
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 10-1878
9. AGE (In years last birthday): 71 (If under 1 Year: Months 1, Days 3; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Benjamin
14. MOTHER'S MAIDEN NAME: Rachel Lane
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Records Balto. City Hospitals ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary infarction LLL — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Arteriosclerotic Heart disease with failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Questionable Thrombophlebitis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2- 23- , 1949 *to* 3- 13- , 1949, *that I last saw the deceased alive on* 3- 13- , 1949 *and that death occurred at* 8.50 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. L. Rogers M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: Mar.14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: 3/15/49
24C. NAME OF CEMETERY OR CREMATORY: WHITMER
24D. LOCATION (City, town, or county) (State): ELKINS, W. VIRGINIA

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 S Paca St.

VS 15b

61

G72418 G72418

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles L. Hess
2. DATE OF DEATH: 3/13/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
   B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
   C. Length of stay in Baltimore: Yrs. Mon. Days
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission): A. STATE: Md B. COUNTY
   C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
   D. STREET ADDRESS (If rural, give location): 937 Gorsuch Ave. 9-05
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 5/28/1876
9. AGE (In years last birthday): 72 — If Under 1 Year: Months 9, Days 15 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hauling
10B. KIND OF BUSINESS OR INDUSTRY: Own Business
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Fred Hess
14. MOTHER'S MAIDEN NAME: Kate Keener
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Ruby Hess ADDRESS: 937 Gorsuch Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: John R Davis M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 3/14/49

24A. BURIAL, ~~CREMATION, REMOVAL (SPECIFY)~~: Burial
24B. DATE: 3/17/44
24C. NAME OF CEMETERY OR ~~CREMATORY~~: Balto.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 15 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 151

93D

G72419 CERTIFICATE CORRECTED 3/31/49. ✓ BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 916 ○ G72419 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GROVER JUSTICE N-948

2. DATE OF DEATH March 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 939 West Lombard Street 1 8 3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Single	January 28, 1928	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Recorder	Steel Co	Jenkin Jones W. Va. Kentucky	

13. FATHER'S NAME Claud Justice

14. MOTHER'S MAIDEN NAME Mary Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Lynn B. Jackson	2205 W. Pratt St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Second and third degree burns of 85% of the body
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 939 West Lombard Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 3 13 49 ? m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? Oil stove overturned--house afire

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L. Kaye M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR | 23C. DATE SIGNED March 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	3/15/49	Williamson	W. Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Huntington for Williams, M.D.	Wm Cook Inc	1217 St. Paul St.

VS 151

180

G72420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 916.0 G72420 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (CARVEL) Carvel Owens — N.968

2. DATE OF DEATH March 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 939 N. Lombard Street 18 3

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	6/12/908	40	9 / 1	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Calvert Distillery	Va.	

13. FATHER'S NAME Elihu Owens

14. MOTHER'S MAIDEN NAME Emmaline Fuller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Lynn B. Jackson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carbon Monoxide Poisonin.	
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) Acute alcoholism	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ ~~CAUSE OF~~ DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 939 N. Lombard Street
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY March 13, 1949 ? A.m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21F. HOW DID INJURY Ooccur? Oil Stove overturned—house afire

22. *I certify that I took charge of the remains described above, held an* Ins. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L. Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 3-13-9

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	3/15/49	Grundy	Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 15 1949	Certified for Williams, H.	Wm Cook Inc 1217 E. Pratt St.

VS 151

180

G72421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72421

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Annie E. Kammer

2. DATE OF DEATH 3/13/49 8:10 a.m.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1024 E. Chase St

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1024 E. Chase St. 10 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Widowed	Nov 23rd 1875	73	3 20	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	Self	Balto Md.	

13. FATHER'S NAME Edward Treso

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Gertrude Bernsberg	312 Emory St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis Pebrobe Cardio Vascular disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/11 *, 19*49*, to* 3/13 *, 19*49*, that I last saw the deceased alive on* 3/12 *, 19*49*, and that death occurred at* 8:10 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Irvin S. Blum M.D.	1115 N Calvert St	3/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/16/49	St. Peters	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Deputy for Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 150

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G72422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72422

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN DAVIS

2. DATE OF DEATH February 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 519 West Franklin Street 17 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white		Unknonw	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Unknown	Unknown	Unknown	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
Unknown		Unknown	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Royer M.D.		Feb. 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	MAR 14 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 151

925

G72423

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72423

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice H Dyson

2. DATE OF DEATH: 2/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1510 E. Pratt St. 3-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Unknown	Unknown	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown	Unknown	Unknown	Unknown

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown		Unknown	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uterine Sclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Paul L Boyer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 2/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Medical School

24D. LOCATION (City, town, or county) (State): MAR 14 1949

DATE RECEIVED BY REGISTRAR: MAR 9 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: Commissioner of Health

ADDRESS

VS 151

97

BIRTH NO. 6772424

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

150.0

Registered No. 6772424

1. NAME OF DECEASED (Type or Print): Sarah Pinerman

2. DATE OF DEATH: March 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2476 Shirley Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2905 Rockrose Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1877
9. AGE (In years last birthday): 72 — Months — Days — Hours — Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Morton Potts
14. MOTHER'S MAIDEN NAME: Jeannette ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: William Pinerman — ADDRESS: 2314 Ocala Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremic Poisoning	5 days
DUE TO (B)	Arteriosclerosis	3 months
		2 yrs.
DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ? 19 47, *to* Mar 14, 1949 *that I last saw the deceased alive on* Mar 12, 1949, *and that death occurred at* 6:15 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Leo A. Kolmer M.D. M. D.
23B. ADDRESS: 3700 Park Heights Ave
23C. DATE SIGNED: Mar 4 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 15, 1949
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run Cem
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 15 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 150

1312

CERTIFICATE CORRECTED 4-5-49

72425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72425

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Stella Bantz Evans

2. DATE OF DEATH: March-14-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1832 Bolton Street
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City, Maryland
D. STREET ADDRESS (If rural, give location): 1832 Bolton Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Single	Aug-7-1862	86-7-7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Baltimore, Md.	U. S. A.

13. FATHER'S NAME: Edward (Evans) Bantz

14. MOTHER'S MAIDEN NAME: Malinda Coblentz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
None	None	None	Mrs. Blanche B. Pennington	1832 Bolton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocarditis
DUE TO Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: Gradual

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1930 *to* March 14, 1949 *that I last saw the deceased alive on* Mar 13, 1949, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	140 St Paul Ave	3/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	March-16-1949	Loudon Park	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Tunstall Williams, M.D.	Stewart & Mowen Company	108 W. North Ave.

VS 150

92) Baltimore #1.

ANGle

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72426 — Registered No. G72426

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EMILY VIRGINIA ANGLE

2. DATE OF DEATH: 3-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq. Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt.
D. STREET ADDRESS (If rural, give location): 911 Mondal St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 1 Day: Hours	Min.
F	W	Widowed	8-1-1874	75		12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H W		Balto Md.	USA

13. FATHER'S NAME: William J. Taylor

14. MOTHER'S MAIDEN NAME: Anna Wilhelm

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Marie Wheatley — ADDRESS: 2931 Baker St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Chronic nephritis	yrs.
DUE TO	(B)	Renal lithiasis	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		Bronchopneumonia	1 week

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-6, 1949 *to* 3-13, 1949 *that I last saw the deceased alive on* 3-13, 1949 *and that death occurred at* 6:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. J. Laham M. D.	Franklin Sq. Hosp	3-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	3/17/49	Western Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Tuntington for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

1310

772427

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 772427

1. NAME OF DECEASED (Type or Print): ROBERT W. OWENS, JR.

2. DATE OF DEATH: March 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2730 Louise Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2730 Louise Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
male	white	widowed	Nov. 17, 1871	77 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lawyer		A. A. County, Md.	

13. FATHER'S NAME: R. W. Owens, Sr.

14. MOTHER'S MAIDEN NAME: Ida Randall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-		Mr. Eben F. Perkins	3508 Fairview Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	Sudden
DUE TO	Arterio Sclerosis	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO	Senility	
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Age	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
None		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ WHILE NOT AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.	None	

22. *I hereby certify that I attended the deceased from* [illegible] 19[illegible] *to* March 12 19[illegible] *that I last saw the deceased alive on* March 8, 19[illegible] *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. D. Keyser M. D.	Baltimore, Md.	3/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/15/49	Greenmount Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Hunter for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

94a

G72428

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72428

1 NAME OF DECEASED (Type or Print): Paul H. Schafer

2 DATE OF DEATH: 3/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 229 East Heath St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 229 East Heath Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	M	4/19/1884	64	10 25	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Rigger	U.S. Ind. Chem. Co.	Germany	

13. FATHER'S NAME

14 MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No			Family - Same	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach with
DUE TO metastases to
liver and Mesentery

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C) Acedosis — 1 Week
due to vomiting

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
12/2/48	Carcinoma of Stomach - Metastases Liver	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov ___, 19__ *to* March 14, 1949 *that I last saw the deceased alive on* 3/14/49, 19___, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Isaac Miller MD M. D.	1 E. Chase St.	3/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
B	3/17/49	Cedar Hill	Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Registrar for Williams, J.	James L. McCarthy	130 E. Fort Ave.

VS 150

46B

G72429

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72429

1. NAME OF DECEASED (Type or Print): MRS. JOSEPHINE GERTRUDE SCHLINKMANN

2. DATE OF DEATH: 13 MARCH 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Maryland; B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1313 Eutaw Place (17)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore Eye, Ear & Throat Charity Hospital

c. Length of stay in Baltimore: 4 Yrs. 6 Mos. 10 Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	6 Jan 1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Martinsburg W. Va

12. CITIZEN OF WHAT COUNTRY? U-S.

13. FATHER'S NAME: Hugh McDonald

14. MOTHER'S MAIDEN NAME: Mary Marten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Nephew ADDRESS: Thomas G. Hartley 624 Plymouth Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Acute Coronary Occlusion	15 mins.
DUE TO		
(B)	Arteriosclerosis	over 13 yrs
DUE TO		
(C)	Diabetes	13

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 9 March 1949

19B. MAJOR FINDINGS OF OPERATION: Cataract Removed from right eye

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Natural Death

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): None

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: None

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? None

22. *I hereby certify that I attended the deceased from* 9 March, 1949, *to* 13 March, 1949, *that I last saw the deceased alive on* 13 March, 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph C. Brumbach Jr. M. D.

23B. ADDRESS: Balto. Ey & Ear Hospital

23C. DATE SIGNED: 13 March 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3/16/49

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: MAR 15 1949

REGISTRAR'S SIGNATURE: Thurston for Williams, M.D.

25. FUNERAL DIRECTOR: J. B. Hebbert & Son ADDRESS: 1300 Eutaw Pl

VS 150

61 17

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

72-30 BIRTH NO. B-49-01649 — 50 — Registered No. 672-30

1. NAME OF DECEASED (Type or Print): Stephen H-Heim
2. DATE OF DEATH: 3-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
C. Length of stay in Baltimore: Yrs. 12 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 435 Ingleside Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	26 Jan. 49		1	15	X	X

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: William A. Heim
14. MOTHER'S MAIDEN NAME: Ellen Harding
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Wm. A. Heim
ADDRESS: 435 Ingleside Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Bronchitis, Acute	2 wks.
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Malnutrition	

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 2-26-1949 *to* 3-12-1949 *that I last saw the deceased alive on* 3-12-1949 *and that death occurred at* 8 15/P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard C. Hayden M.D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 3-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-16-49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 14 1949
REGISTRAR'S SIGNATURE: Thurston for Williams, M.D.
25. FUNERAL DIRECTOR: J. Bernard Sullivan Son
ADDRESS: 1300 Eutaw Pl.

VS 150

106a

72431

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

16 ✓ Registered No. G72431

1. NAME OF DECEASED (Type or Print) William Kerr

2. DATE OF DEATH 3-13-49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp. - Green & Lombard Sts.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: resided before admission)
a. STATE Dundalk b. COUNTY Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)
d. STREET ADDRESS (If rural, give location) 2905 Dundalk Avenue

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE (MARRIED) WIDOWED DIVORCED (Specify)

8. DATE OF BIRTH June 6, 1904 | 9. AGE (In years last birthday) 44 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker

10B. KIND OF BUSINESS OR INDUSTRY Steel Industry

11. BIRTHPLACE (State or foreign country) Scotland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Kerr

14. MOTHER'S MAIDEN NAME Jeanie Hastie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no

16. SOCIAL SECURITY NO

17. INFORMANT Elsie Kerr, 2905 Dundalk Ave. ADDRESS Dundalk Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Liver

DUE TO

(B) Cerebral Hemorrhage

DUE TO

(C) Cardiac Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION Feb 1948 | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23A. SIGNATURE Howard E. Hall M. D. | 23B. ADDRESS Mercy Hosp. Green & Lombard | 23C. DATE SIGNED 3/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE March 16 1949 | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | 24D. LOCATION (City, town or county) (State) 7225 Eastern Blvd., Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 15 1949 | REGISTRAR'S SIGNATURE Emily for Williams | 25. FUNERAL DIRECTOR Roland L. Fisher | ADDRESS 2112 Dundalk Ave

VS 150

2

479

G724332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

G724332 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr. Roger Kromm

2. DATE OF DEATH 3/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital

C. Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Dundalk
D. STREET ADDRESS (If rural, give location) 2853 Liberty Pkwy

5. SEX Male
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 10 1895
9. AGE (In years last birthday) 53 — Under 1 year: Months, Days; Under 1 day: Hours, Min. 9 13
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical foreman
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Louis Kromm
14. MOTHER'S MAIDEN NAME Jessie Conger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) No
16. SOCIAL SECURITY NO
17. INFORMANT Reginald Reuard ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebro-vascular Accident
DUE TO
(B)
DUE TO
(C) Pulmonary Atelectasis Ft.
Pulmonary Tuberculosis, Inactive

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 3/12/49
19B. MAJOR FINDINGS OF OPERATION Trephine - Cerebral Hemorrhage
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-10, 1949 to 3-13, 1949, that I last saw the deceased alive on 3-13, 1949, and that death occurred at 1:05 P m., from the causes and on the date stated above.

23A. SIGNATURE T. Kay Morrow M.D.
23B. ADDRESS Church Home & Hosp.
23C. DATE SIGNED 14 Mar. 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE March 16, 1949
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 15 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR ADDRESS Roland L. Fisher, 2112 Dundalk Ave.

VS 150

839

G72433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

591 G72433 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Miranda Bailey
2. DATE OF DEATH: 3/13/49
3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3316 Fairfield Rd
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived, or institution if residence before admission): A. STATE 3316 Fairfield Rd
c. CITY OR TOWN (If outside corporate limits write RURAL and give township): Balt Md
D. STREET ADDRESS (If rural, give location): 3316 Fairfield Rd
5. SEX: Female
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 77 — If under 1 Year: Months Days — If under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Rosia Goines
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Carrie Tolbert — ADDRESS: 3316 Fairfield Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Nephritis + Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/1/49 *to* 3/13/49, *that I last saw the deceased alive on* 3/12/49 *and that death occurred at* 12 M., *from the causes and on the date stated above.*

23A. SIGNATURE, M. D.: W. R. Wells
23B. ADDRESS: 2134 Druid Hill Ave
23C. DATE SIGNED: 3/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 17 1949
24C. NAME OF CEMETERY OR CREMATORY: Bailey Cemetery
24D. LOCATION (City, town, or county) (State): Virginia
DATE RECEIVED BY LOCAL REGISTRAR: MAR 17 1949
REGISTRAR'S SIGNATURE: Deputy for Williams
25. FUNERAL DIRECTOR: C. Wilson
ADDRESS: 1515 McElderry St

VS 150

131a

72434

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72434

1. NAME OF DECEASED (Type or Print) Harriet Maith

2. DATE OF DEATH 3/13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1611 N. Carey St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 40 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1611 Carey Balto md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto md
D. STREET ADDRESS (If rural, give location) 1611 N Carey St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
Female	negro	single	9-15-1879	69 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Northumberland Co Va	

13. FATHER'S NAME Andrew Maith

14. MOTHER'S MAIDEN NAME Ann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		Jerome Maith	1611 Carey

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Dilatation (Chron)
DUE TO
(B) Chron Gastritis
DUE TO
(C) Myocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1948, 19__ *to* 3-13-, 1949, *that I last saw the deceased alive on* 3-10, 1949, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
Mark R. Bogley M. D.	1133 W Mount	3/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/16/49	Mt Auburn	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Chester for Williams, M.D.	Geo. G. Kelson	1103 Presstman St.

VS 150

309

672435

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 672435

1. NAME OF DECEASED (Type or Print): Thomas M. O'Hare

2. DATE OF DEATH: March 13 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland: Baltimore Md.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3534 Chestnut Ave

c. Length of stay in Baltimore: Life — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Md.
D. STREET ADDRESS (If rural, give location): 3534 Chestnut Ave 13 06

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct 22 1880
9. AGE (In years last birthday): 69 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: City of Balto
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? Us
13. FATHER'S NAME: James M. O'Hare
14. MOTHER'S MAIDEN NAME: Mary H. Boone
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mary E. O'Hare ADDRESS: 3534 Chestnut Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) arteriosclerosis — 1 year
DUE TO
(C) age —

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1940 *to* March 13, 1949, *that I last saw the deceased alive on* March 13, 1949, *and that death occurred at* 12 15 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Gilbert L. Mortimer M. D.
23B. ADDRESS: 2706 St Paul St
23C. DATE SIGNED: 3/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 16 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem
24D. LOCATION (City, town, or county) (State): Old Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR: MAR 17 1949
REGISTRAR'S SIGNATURE: Martin for Williams Reg
25. FUNERAL DIRECTOR: John C. Moran ADDRESS: 3000 E. Baltimore St

VS 150

838

G724336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G724336

Registered No. 3698

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lillie WATERS

2. DATE OF DEATH 3-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 618 N. Mount St.

c. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D STREET ADDRESS (If rural, give location) 618 N. Mount St.

5. SEX female

6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH 5-3-1886

9. AGE (In years last birthday) 62 If under 1 Year: Months Days If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work

10B. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Church Creek Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Alexander Plater

14. MOTHER'S MAIDEN NAME Lonnie Caine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No

16. SOCIAL SECURITY NO

17. INFORMANT Greenwood Waters ADDRESS 618 N. Mount St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma uteri
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 mo

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-1 , 1948 *to* 3-12 , 1949 *that I last saw the deceased alive on* 3-12 , 1949 *and that death occurred at* 11:42 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Frank A. Saunders M. D.

23B. ADDRESS 1029 N. Stricker St.

23C. DATE SIGNED 3-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 3/17/49

24C. NAME OF CEMETERY OR CREMATORY Arbutus

24D. LOCATION (City, town, or county) (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 15 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Geo. C. Kelson 1303 Presstman st.

VS 150

480

G72437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72437

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie Hebb

2 DATE OF DEATH: May 12, 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 560 Baker St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto.
D. STREET ADDRESS (If rural, give location): 560 Baker St 14 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	May 20, 1890	58	9 / 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Domestic		St Mary's Co Md.	U. S.

13. FATHER'S NAME: William Hebb

14 MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Albert Hebb	560 Baker St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cardio Vascular Disease	3 yrs.
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)	Hypertension	3 yrs
DUE TO		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Feb 10, 73 1946 to May 12, 1949 that I last saw the deceased alive on Feb 24, 1949, and that death occurred at 1 73 A.m., from the causes and on the date stated above.

23A. SIGNATURE	23B ADDRESS	23C. DATE SIGNED
E William Frey M. D.	1928 Penna Ave	3/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	3/16/49	St. Peter's	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Deputy for Williams, M.D.	Geo. F. Nelson	1303 Eastern Ave.

VS 150

937

G72438

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 16

G72438

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Florence Thomas Morris

2. DATE OF DEATH: 3.13.1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 116 N. Schroeder St
C. Length of stay in Baltimore: 20 Yrs. / Dys.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 116 N. Schroeder St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
female	Colored	Married	April 1904	44	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	—	Virginia	U.S.A.

13. FATHER'S NAME: Grant Thomas

14. MOTHER'S MAIDEN NAME: Sue Malone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	Not Known	Lonnie Thomas	116 N. Schroeder

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Rheumatic Heart Disease	14 yrs.
DUE TO (B)	Rheumatic fever	Not Known
DUE TO (C)	Cholecystitis - Hepatitis	11 yrs.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 12.22. 1935 to 3.13. 1949, that I last saw the deceased alive on 3.13. 1949 and that death occurred at 9.00 p m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James M. Pair M.D.	400 N. Carrollton Ave	3.14.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	Mar 16, 1949	Branchville Va.	Branchville Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Walter J. Williams, M.D.	Mrs Katie R. Williams	2224 Schroeder St

VS 150

9513

G72439

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 331 Registered No. G72439

1. NAME OF DECEASED (Type or Print): Paige Elliott Jr.

2. DATE OF DEATH: March 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural give location) 825 Sarah Ann St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 825 Sarah Ann St.

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Col.	Married	July 2, 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Gardner	—	Eastern Shore Md.	U.S.A.

13. FATHER'S NAME: Paige Elliott Sr.

14. MOTHER'S MAIDEN NAME: Mary Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No.	—		Etta Elliott	825 Sarah Ann St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 days

DUE TO

(B) Pulmonary Congestion

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/22/49 *to* 3/12/49, *that I last saw the deceased alive on* 3/12/49, *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	252 Cross St	3/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Mar 15, 1949	Western Star	Catonsville, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Martin for Williams, M.D.	Mrs Katie R. Williams	3224 Edmondson Ave

VS 150

83a

G72440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72440

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Theodore Wallace

2. DATE OF DEATH: March 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1226 Division St.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1226 Division St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
Male	Col.	Single	Sept. 23, 1928	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Balto. Md.	U.S.A.

13. FATHER'S NAME: Arthur Wallace

14. MOTHER'S MAIDEN NAME: Ida. Hamilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.			Arthur Wallace	1226 Division St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

(B) This patient was at City Hospitals sometime before I was called in

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 14-49 *to* 3-13-49, 19__, *that I last saw the deceased alive on* 3-13-49, *and that death occurred at* __ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ess Cardozo M.D.	1624 Druid Hill Ave	3-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	3-16-49	Mt. Auburn Cem	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 17 1949	Printed for Williams	Mrs Katie R Williams	322 N. Stricker St

VS 150

13B

G72441 ✓ 31

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G72441 Registered No.

1. NAME OF DECEASED (Type or Print): MARGARET HIPCHEN

2. DATE OF DEATH: MARCH-14 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1411 CHARKSON ST
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore ? Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE 110 BURNETT ST.
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE MD
D STREET ADDRESS (If rural, give location)

5. SEX	6 COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
FEM.	WHITE	WIDOW	MAY 22-1861	87		

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK. AT HOME
10B KIND OF BUSINESS OR INDUSTRY: —
11 BIRTHPLACE (State or foreign country): GERMANY.
12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: GEORGE GERSTNER
14 MOTHER'S MAIDEN NAME: NOT KNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16 SOCIAL SECURITY NO: —
17 INFORMANT: MRS GEO. JENSSEN
ADDRESS: 1411 CHARKSON ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(B) arterio-sclerosis — ?
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none
19B MAJOR FINDINGS OF OPERATION: —
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 10, 1949, to March 14, 1949, that I last saw the deceased alive on March 13 1949, and that death occurred at 1 A m., from the causes and on the date stated above.

23A. SIGNATURE: James E. Peterman M.D.
23B ADDRESS: 1226 Hanover St.
23C DATE SIGNED: 3/14/49

24A BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: MARCH. 16-49
24C. NAME OF CEMETERY OR CREMATORY: HOLY CROSS CEM.
24D LOCATION (City, town, or county) (State): A. A Co.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 15 1949
REGISTRAR'S SIGNATURE: Registrar for Baltimore, Md.
25 FUNERAL DIRECTOR: Bernard C. Hark
ADDRESS: 121 E West St

VS 150

83a

CERTIFICATE CORRECTED 2-18-49

G72442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G72442

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Josh P. D. Shifflett

2. DATE OF DEATH March 11. 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore City.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4003 EASTERN AVE

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4003. Eastern ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White.	Married.	March 30 1870	78 79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		(West) Virginia	

13. FATHER'S NAME John.

14. MOTHER'S MAIDEN NAME Anderson.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. DNR.

17. INFORMANT Mrs. Pearl. Long. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chr. Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 10, 1947 *to* 3-11-, 1949 *that I last saw the deceased alive on* 3-10, 1949, *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
N. J. Davidow M. D.	3218 Eastern ave	3-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial.	March [redacted]	Saint. Matthia	Odonnell. Street.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	[redacted]	WENDELL J. DIPPEL	

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G72443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G72443

BIRTH NO. B. 2-49-04778 — Registered No. 154

1. NAME OF DECEASED (Type or Print): Baby Girl Kleinen

2. DATE OF DEATH: March 11 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days: 6 0 8

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 107 N. Montford Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Child	3-4-49			8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Richard Kleinen

14. MOTHER'S MAIDEN NAME: Doris Matthew

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-4, 1949, *to* 3-11, 1949 *that I last saw the deceased alive on* 3-11, 1949, *and that death occurred at* 8 10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P. B. Hoeson M. D.	JOHNS HOPKINS HOSPITAL	3-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/14/49	Sacred Heart	Hereon Hill Rd. Notte, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Huntington Williams, M.D.	John D. Connelly	Essex 21, Md.

VS 150

157E

BK. 108459

G72444

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72444 Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Gibbs

2. DATE OF DEATH: 3- 12- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 16 N. Bond ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	Negro	Single	Nov, 22- 1908	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	

13. FATHER'S NAME: Joseph Gibbs SR.

14. MOTHER'S MAIDEN NAME: Emma Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Records Balto. City Hospitals	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Pulmonary Tuberculosis	10 Years
	DUE TO		
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)		
	DUE TO		
	(C)	Pulmonary Edema Post Operative	4 Days
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT			

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
3-7-49	Normal Anatomy	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 2- 14- , 1947, *to* 3- 12- , 1949, *that I last saw the deceased alive on* 3- 12- 1949, *and that death occurred at* 3.50A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
G. S. Gross M. D.	B.C.H. 4940 Eastern Ave.	3-12-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/17/1949	Mt. Calvery Cem.	Brooklyn A.A.Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Deputy for Williams, M.D.	Elroy O. Wilson	1000 Brantly Ave.

VS 150

8

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G72445

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G72445 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ARTHUR (STITK) STITH (SMITH)

2. DATE OF DEATH: March 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1507 Fairmount Avenue
c. Length of stay in Baltimore: Io Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1507 Fairmount Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	Colored	Single	4/17/1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Virginia	U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		Mason Johnson	124 N. Colvin St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO (B)
DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, inspection or inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Emil Beyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 3-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/15/1949	Mt. Calvery Cem.	Brooklyn A.A.Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Assistant for Williams, M.D.	Elroy O. Wilson	1000 Brantly Ave

VS 151

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G72446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

490

G72446

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margret Mason

2. DATE OF DEATH 3/13/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 732 N. Fulton Ave.

c. Length of stay in Baltimore Io Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived at time of death. If institution, residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Maryland
D. STREET ADDRESS (If rural, give location) 732 N. Fulton Ave. 16-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col.	Married	Aug. 14. 1917	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Accomac Co Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Cutler	Zennie Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		William Mason	2.Oak St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Consolidation

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 2 1949 *to* March 13 1949 *that I last saw the deceased alive on* March 13 1949, *and that death occurred at* 5:08 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Calvin L. White M. D.	1802 Penna Ave.	3-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/17/1949	Mepomkin Cem.	Accomac Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 17 1949	Thomas for Williams, M.D.	Elroy C. Wilson	1000 Brantly Ave.

VS 150

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G72447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72447

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS LYDA ALLEN 416

2. DATE OF DEATH: 3-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 40 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 958 W. Balto St. R-1

5. SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8 DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	M	6-8-90	58		

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife	Home	Md.	U.S.A.

13. FATHER'S NAME: Samuel Thomas

14 MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
		Peter Allen	Eastland ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Thrombosis	7 days
DUE TO (B)	Rheumatic Heart disease	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	Myxedema	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-12-1949 *to* 3-17-1949, *that I last saw the deceased alive on* 3-14-1949, *and that death occurred at* 9 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B ADDRESS	23C DATE SIGNED
A F Judd M. D.	Mercy Hospital	3-14-49

24A. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY OR ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	March 16/49	East New Market, Md	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25 FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	Hunting for Williams, M.D.	Harry E Daily	1900 Eastern Ave

VS 150

95B

G72448

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72448

1. NAME OF DECEASED (Type or Print): MRS Rosa. Fox

2. DATE OF DEATH: MAR 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Church Home

C. Length of stay in Baltimore: 8 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Church Home, Broadway & Jan...

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: Oct. 8, 1860
9. AGE (In years last birthday): 88 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Odos Michigan
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Blair

14. MOTHER'S MAIDEN NAME: Mary Burch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Earle B. Fox ADDRESS: 2 Taney Ave, Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO
(B) Arteriosclerosis, generalized — 8
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1 1947 *to* MAR. 14, 1949 *that I last saw the deceased alive on* MAR 14, 1949, *and that death occurred at* 5 45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. M. Howard, M.D.
23B. ADDRESS: Church Home and Hospital
23C. DATE SIGNED: 3-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: MAR. 15, 1949
24C. NAME OF CEMETERY OR CREMATORY: MORRIS CEM.
24D. LOCATION (City, town, or county) (State): MORRIS, N.Y.

DATE RECEIVED BY LOCAL REGISTRAR: MAR 15 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: WILLIAM COOK INC ADDRESS: 1217 ST. PAUL ST.

VS 150

937

672449 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4201 Registered No. 672449

1. NAME OF DECEASED (Type or Print): REUBEN GOLD

2. DATE OF DEATH: March 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

C. Length of stay in Baltimore: 45 Yrs. -Mo. -Dys.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 11-03 Congress Hotel. 310 West Franklin St., Congress Hotel

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	Jan. 17, 1884	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Restaurant Prop.		London, England.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Isaac Gold	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Jack L. Medwedeff, ADDRESS: Munsey Bldg.
?		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary artery disease	
	DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Carl L Voss M.D.		March 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/16/49.	Har Sinai	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
MAR 15 1949		David Lowenstein & Son. 1902 Eutaw Place.

VS 15Y

94a

G72450

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G72450

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES WILLIAMS

2. DATE OF DEATH: 3/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): 9-7 W. [illegible] St., 18 01
D STREET ADDRESS (If rural, give location):

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General

C. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	Col		Unknown	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown		Unknown	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown		Unknown	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
John R Davis M.D.		3/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Johns Hopkins Medical School	MAR 15 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
MAR 15 1949	[illegible] for Baltimore, Md.	Commissioner of Health	

VS 151

939

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

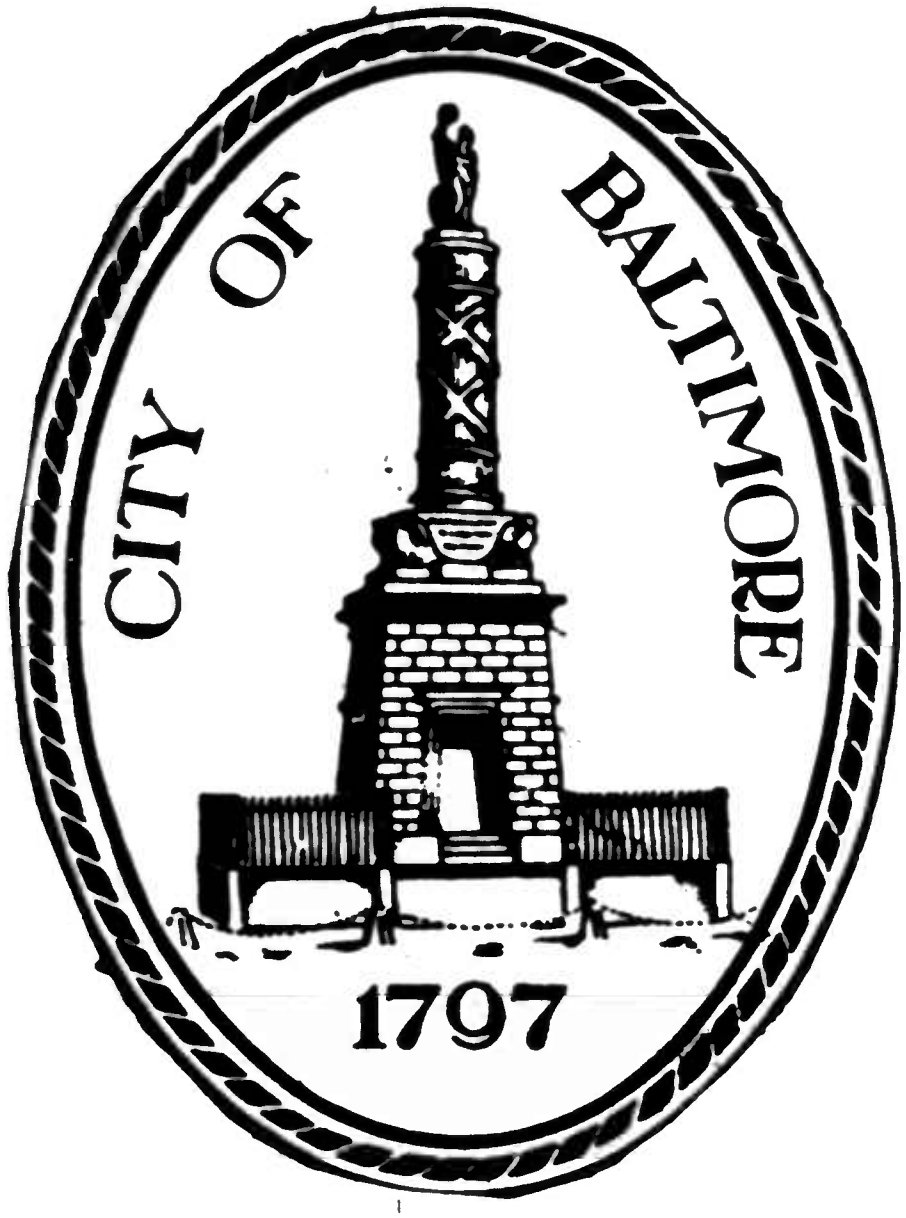
RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 9-10 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 69101 AND ENDING WITH 72450 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne
Asst Supv.



END OF REEL